

1 OCTOBER 2000



Health Services

PATIENT ADMINISTRATION FUNCTIONS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

NOTICE: This publication is available digitally on the AFDPO WWW site at: <http://afpubs.hq.af.mil>.

OPR: HQ AFMOA/SGOI
(Col Michael J. Fitzwater)
Supersedes AFI 41-210, 26 July 1994.

Certified by: HQ AFMOA/SGOI
(Capt Crystal Burris)
Pages: 102
Distribution: F

This instruction implements AFD 41-2, *Medical Support*. It provides requirements and outlines, activities, policies, and procedures for patient administration. It describes how to manage patient administration functions, including protecting medical information, managing health records, preparing and dispositioning of medical documentation and managing administration activities supporting patients. Organizational alignment of these functions may vary between medical treatment facilities. This instruction directs collecting and maintaining information subject to the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. This instruction applies to all Air Force medical units and Air Reserve components where functions are performed. System of records notice F044 AF SG E applies.

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

This revision adds guidance on sequestering records (paragraph **1.1.4.**); provides additional guidance on procedures for releasing medical information for research (paragraph **1.4.8.**); provides specific guidelines for release of information from Active Duty members' records (paragraph **1.4.9.**); updates record handling for technology (paragraphs **1.5.**, **2.9.**, and **2.10.**); addresses record handling for deployments (paragraph **2.6.** and **2.7.**); management of records during base closure activity (paragraph **2.12.**); reorganizes **chapter 3** to address patient centered functions; adds a new chapter on ambulatory administration which includes information on ambulatory procedure visits, observation and partial hospitalization (**chapter 4**); adds procedures for readmitting patients (paragraph **5.12.**); includes instructions for canceling admissions (**attachment 11**); adds information on the biometric data collection process, and establishes requirements for data quality programs and assignment of responsibility (**chapter 6**); adds information on processing death cases (**attachment 10**); includes information on emergency room deaths, master patient index, inpatient folder preparation and other inpatient processing (**attachment 11**); adds definition of reportable visit (**attachment 12**), adds validation of workload procedures (**attachment 13**).

Chapter 1—LEGAL ASPECTS OF HEALTH RECORDS	5
1.1. Safeguarding Medical Information.	5
1.2. Laws Affecting Disclosure of Medical Information.	6
1.3. General Guidelines on Releasing Medical Information.	8
1.4. Releasing Information to Certain Persons and Agencies.	10
1.5. Sending/Receiving Medical Information via Telefax, Electronic Mail (E-Mail) or Other Similar Methods	14
Figure 1.1. Sample Format –Facsimile Cover Letter.	15
Figure 1.2. Sample Format—Misdirected Facsimile Cover Letter.	17
1.6. Power of Attorney.	18
Chapter 2—WORKING WITH HEALTH RECORDS	19
2.1. Documenting Health Records.	19
2.2. Managing Health Records.	19
2.3. Correcting Health Records.	19
2.4. Reviewing Health Records.	19
2.5. Preparing and Filing Health Records.	20
2.6. Management of Inpatient Records Created at Deployed Air Transportable Hospitals (ATH) and Contingency MTFs	20
2.7. Management of Outpatient Records Pre and Post Deployment.	20
2.8. Management of Records for Personnel in the Nuclear Weapons Personnel Reliability Program (PRP).....	21
2.9. Automation of Health Records.	21
2.10. Documentation of Telemedicine.	21
2.11. Disposition (Transfer or Retirement) of Records to National Personnel Records Center (NPRC), the Department of Veterans Affairs (DVA) or the Civilian Personnel Office (CPO)	22
2.12. Base Closures and Medical Records Management.	24
2.13. Requests for Medical Records.	25
Chapter 3—ADMINISTRATION OF PATIENTS	26
3.1. Quarters Status	26
3.2. Line of Duty (LOD) Determinations:	26
3.3. Utilizing the AF Form 570, Notification of Patient’s Medical Status for Special Administrative Actions	26
3.4. Electing Optional Civilian Medical Care	27

Chapter 4—AMBULATORY PATIENT ADMINISTRATION **28**

4.1. General Information.	28
4.2. Creation and Maintenance of Health Records in Clinics:	28
4.3. Disposition of Outpatient Records	29
4.4. Missing/Lost Records	30
4.5. Extended Ambulatory Records (EAR)	30
4.6. Ambulatory Procedure Visit (APV) Records.	30
4.7. Observation Records	32
4.8. Partial Hospitalization	33
4.9. Records Transmittal and Receipt	34
4.10. Prenatal Records	35
4.11. Secondary Records.	35

Chapter 5—INPATIENT ADMINISTRATION **36**

5.1. Admitting and Discharging Patients.	36
5.2. Transferring Patients Between MTFs.	36
5.3. Assuming Administrative Responsibility for Military Members Hospitalized in Nonmilitary Medical Facilities	36
5.4. Assuming Administrative Responsibility for Active Duty Air Force Members Hospitalized in Army or Navy Medical Treatment Facilities	37
5.5. Reporting Patients in Casualty Status.	38
5.6. Reporting Infants Born Outside the MTF.	38
5.7. Admitting Generals/Flag Officers and Dependents, Colonels, and Prominent Persons (HAF-SGX (D) 9909).....	38
5.8. Reporting Aircraft Accident Admissions	40
5.9. Managing Military Patients Expected To Be Hospitalized Over 90 Days	40
5.10. Notifying the VA of Admission of a Veteran Who At Any Time Filed a Claim.....	40
5.11. Assigning or Attaching Military Patients	40
5.12. Readmission of Patients.	40
5.13. Canceling Admissions.	41
5.14. Rank for OSI Agents.	41

Chapter 6—MANAGING BIOMETRIC DATA **42**

6.1. The biometric data process.	42
---------------------------------------	----

6.2. Vital nature of biometric data.	42
6.3. Biometric information quality management.	43
6.4. Forms Prescribed.	44
Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION	46
Attachment 2—CORRECTING HEALTH RECORDS	52
Attachment 3—PREPARING AND FILING HEALTH RECORD FOLDERS	53
Attachment 4—DISPOSITION OF SPECIFIC PATIENTS	64
Attachment 5—TRANSFERRING PATIENTS	69
Attachment 6—OUTPATIENT RECORDS MAINTENANCE	71
Attachment 7—CASUALTY REPORTING	77
Attachment 8—BIRTH REGISTRATION	79
Attachment 9—CONTENTS OF INPATIENT RECORD	81
Attachment 10—PROCEDURES RELATING TO DECEASED PATIENTS	88
Attachment 11—INPATIENT RECORDS ADMINISTRATION	92
Attachment 12—DEFINITION OF A REPORTABLE VISIT	99
Attachment 13—VALIDATION OF REPORTED WORKLOAD	102

Chapter 1

LEGAL ASPECTS OF HEALTH RECORDS

1.1. Safeguarding Medical Information.

1.1.1. Information in the health record is personal to the individual and will be properly safeguarded. Take necessary precautions to avoid compromise of medical information during the movement of the record within and outside the military treatment facility (MTF). Only medical personnel are authorized access to the information except as noted elsewhere in this chapter.

1.1.2. Limit access to all open record storage areas and to electronic records, to authorized personnel only.

1.1.3. Establish procedures to ensure highly sensitive records and sensitive medical information are safeguarded. This includes copying electronic records for inclusion into the hard-copy record, safeguarding x-rays and fetal monitoring strips. Drug and alcohol abuse, rape, child or adult abuse and possible claims against the government are examples of highly sensitive records. See paragraphs, 1.3.3.3 and 2.12.4 for guidance on litigation cases. Information which may affect the patient's morale, character, medical progress or mental health is considered sensitive. To protect the sensitive nature of the information, send the records or documents directly through the medical channels when considered advisable by the physician or MTF Commander.

1.1.4. The MTF may sequester the original medical record or a certified copy when the situation warrants. If a certified copy is made for sequestering, return the original record to the file room and suspend it for periodic updates. Some recommendations on when to sequester the original outpatient record are as follows:

1.1.4.1. When a claim has actually been filed.

1.1.4.2. When the patient has tried to tamper, alter, or illegally remove a record from the facility.

1.1.4.3. When a request is received from an attorney under circumstances indicating a claim is being considered.

1.1.4.4. When an Inspector General (IG) or Congressional Inquiry or Investigation has been initiated by the patient.

1.1.4.5. When the record becomes relevant to an Office of Special Investigation (OSI) or Security Police investigation.

1.1.4.6. See AFI 44-119, *Medical Clinical Performance Improvement*, Chapter 8, paragraph 8.5.2 for more guidance.

1.1.4.7. It is the MTF Commander's responsibility (with Quality Services Manager and/or Staff Judge Advocate's [SJA] advice) to establish local Operating Instructions on how to sequester medical records for safe keeping.

1.1.4.8. In order to track a sequestered record, there should be a cover sheet stating who requested the record be copied or sequestered, why the record has been sequestered, and the date (or occurrence of an event) when the record should be reviewed to determine the need for continued sequestering.

1.1.4.9. The MTF Commander should request an annual review of sequestered records by the base claims officer to determine whether they should continue to be sequestered.

1.2. Laws Affecting Disclosure of Medical Information.

1.2.1. Medical personnel must comply with the Privacy Act, Freedom of Information Act, Drug Abuse Offense and Treatment Act, and Comprehensive Alcohol Abuse amendments. Personnel must periodically contact the Staff Judge Advocate's office for changes to directives.

1.2.2. Privacy Act of 1974.

1.2.2.1. Refer to AFI 33-332, *Air Force Privacy Act Program*, for guidance on the collection, safeguarding, use, maintenance, access, amendment, disclosure of information, and fees for copying records. This AFI explains policy on time periods, denial authority, judicial sanctions, accountability of disclosure, and annual reports.

1.2.2.2. DD Form 2005, **Privacy Act Statement - Health Care Records**, eliminates the need for a separate Privacy Act (PA) statement for each medical, dental or related document requiring individual identifying information. The DD Form 2005 is not a consent form. It serves as evidence that, as prescribed by the PA, the individual was informed of the purpose and uses of the information collected and was advised of his/her rights and obligations with respect to supplying the data. The patient's signature is not mandatory. When the PA statement is printed on the reverse of AF Form 560, **Authorization and Treatment Statement**, or on the record folder, do not use the DD Form 2005. The patient does not sign the PA statement.

1.2.3. Substance Abuse Records.

1.2.3.1. *Public Health Service Act*, 42 U.S.C. 290dd-2.

1.2.3.2. Regulations implementing the above statutes are set out in 42 Code of Federal Regulations (CFR), part 2.

1.2.3.3. Drug and Alcohol Laws take precedence over other directives pertaining to access to information.

1.2.3.4. The SJA reviews health records relating to drug and alcohol abuse or rehabilitation determining their releasability and provides guidance on the nature of the reply to the request for information. If the SJA determines that the record is not releasable under the Drug and Alcohol Abuse Acts, inform the requester that release of the record is prohibited by law. If a portion of the record is not releasable, provide that portion which can be released. Inform the requester that the records being released are all that are allowed for release by law.

1.2.3.5. A general authorization for the release of medical or other information is NOT sufficient for disclosing information from records containing drug or alcohol abuse, treatment or rehabilitation information. To comply with the federal laws, a consent for release of information must include the following:

1.2.3.5.1. Name of facility to release information.

1.2.3.5.2. Name or title of person or organization to receive and use information.

1.2.3.5.3. Name of patient.

1.2.3.5.4. Purpose or need for information.

1.2.3.5.5. Extent or nature of information to be released (for example, narrative summary or outpatient notes and time period to be covered).

1.2.3.5.6. Statement that the consent can be revoked at any time except for that information which has already been released and the specification of the data, event or condition on which the consent will expire, if revoked.

1.2.3.5.7. Consent expiration data.

1.2.3.5.8. Date consent signed.

1.2.3.5.9. Signature of patient or person authorized to sign for the patient.

1.2.3.5.10. Signature of witness when required by State law.

1.2.3.5.11. Statement that future disclosure of the information without written consent of the person is prohibited.

1.2.3.6. Information relating to drug and alcohol abuse or rehabilitation may be disclosed as follows:

1.2.3.6.1. Within the U.S. Armed Forces or between the Air Force and those components of the Department of Veterans Affairs providing health care to veterans.

1.2.3.6.2. To medical personnel to the extent necessary to meet a medical emergency.

1.2.3.6.3. To qualified persons for scientific research, management and financial audits, or program evaluation.

1.2.3.6.4. By an appropriate order of a court of competent jurisdiction after application showing good cause.

1.2.3.7. When information is released (except as authorized in paragraph 1.2.3.6), the disclosure must be accompanied by the following statement: "Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations [42 CFR Part 2 and 42 U.S.C. 290dd-2] prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

1.2.4. Freedom of Information Act (FOIA). See DoD Regulation 5400.7/AF Supplement, *Freedom of Information Act Program*, for specific guidance and procedures related to FOIA.

1.2.5. Patient Self-Determination Act (PL 101-508, Sections 4206 and 4751). The Patient Self-Determination Act (PSDA) mandates that health care institutions inform patients of their rights, according to state law, to make decisions regarding their medical care. This includes the right to accept or refuse treatment and the right to prepare advance directives. An "advance directive" is defined as a written instruction by the patient, in the form of what is commonly known as "living will" or a durable power of attorney for health care, recognized under State law (some states require both) and related to the provision for such care when the patient is incapacitated.

1.2.5.1. Each MTF will establish and maintain written policies and procedures to implement patient's rights to make decisions concerning their medical care. Ensure compliance with State law (whether statutory or as recognized by the courts of the State) respecting advance directives.

1.2.5.2. Provide to all adult patients written information on their rights under the host State's law to make decisions concerning their medical care, including the right to execute an advanced directive and to give provider's the policies to implement those rights.

1.2.5.3. Document in the patient's medical record whether or not the patient has an advance directive. This is documented on the AF Form 560 for inpatient care, either the DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow Sheet**, for outpatient care, and on the automated cover sheet for ambulatory procedure visit (APV) cases. NOTE: The AF Form 1480A has been superseded by the DD Form 2766. Utilize the DD Form for all new records.

1.2.5.4. Provide for education of the staff and community on issues concerning advance directives.

1.2.5.5. Check with your local SJA for further guidelines.

1.2.5.6. The FY 96 DoD Authorization Act includes an important safeguard for military members entitled to legal assistance. The new law creates "military advance medical directives" that are exempt from any requirements of form, substance, formality or recording required by State law. For example, if an Air Force member has a military living will prepared in Florida, but then becomes severely injured in California, the military living will is honored in California even though the document may not conform to California law. There is no civilian equivalent to this Federal protection.

1.2.6. Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191). Health records protection and release will be in compliance with appropriate statutory and regulatory authority to protect, within the guidelines of those laws and regulations, the sanctity of the records.

1.2.7. Privacy Act (5 U.S.C. 552a). Medical records are maintained within a system of records protected by the Privacy Act. The system notice, Medical Record System (F044 AF SG E), identifies the records as inpatient and outpatient records of care received in Air Force medical facilities, and includes secondary files. Disclosure to third parties is prohibited, except pursuant to the written consent of the individual to whom the record pertains or in specified limited circumstances. See 5 U.S.C. 552a(b) and AFI 33-332, *Air Force Privacy Act Program*. Consult the SJA.

1.3. General Guidelines on Releasing Medical Information.

1.3.1. If the information or access to health records is to be provided to nonmedical personnel with a proper and legitimate need the MTF Commander or designee determines the pertinent information to release a requester and whether professional medical assistance should be provided during the record review. Only enough information required to meet the need of the request is provided. Original medical documents or records are not released to any person or agency outside the Executive Branch, except in compliance with a valid court order or as otherwise required by law. Always consult the SJA prior to releasing medical information under these circumstances.

1.3.2. Health records may contain information from nonmilitary sources.

1.3.2.1. A patient can be referred to a nonmilitary source for diagnosis and or treatment under supplemental or cooperative care. Documentation from the nonmilitary source which supports the diagnosis and treatment will be filed in the patient's outpatient medical record. Copies of this documentation are releasable to the patient.

1.3.2.2. Other information from nonmilitary sources, where the patient is not under supplemental or cooperative care, may also be available for further diagnosis, treatment and other official Air Force use. This information cannot be released as it is the property of the originating nonmilitary facility and can be released only by that facility. Advise the patient or requester that additional information is contained in the record and must be requested from the originating facility.

1.3.3. Obtain written consent of the patient concerned or his/her legal representative before release of information from the health record to any person or agency, with the exception of those items outlined in paragraphs [1.4.4.1](#).

1.3.3.1. For deceased persons, the next of kin (NOK) or a court appointed executor or administrator signs written consent and provides proof of death.

1.3.3.2. For under aged, physically, or mentally challenged persons, a parent or guardian signs written consent and furnishes a court order appointing guardianship.

1.3.3.3. If litigation is pending or contemplated, send the request for release to the SJA for advice and appropriate action in accordance with AFI 51-301, *Civil Litigation*. Prepare a locally developed consent form without assigning a form number. Coordinate the wording with the SJA to ensure conformance with local and state laws.

1.3.4. General rules and individual state laws specify when a power of attorney is required. Refer any questions about power of attorney to the SJA.

1.3.5. File all correspondence regarding the release of information in the health record for permanent safekeeping. See paragraph [1.4.5](#) for special instructions pertaining to release to Department of Defense (DoD) Investigative Agencies.

1.3.6. Fees for copying, certifying and searching health records are listed in AFI 33-332, paragraph 4.3.

1.3.6.1. When providing copies of Privacy Act protected records, provide the first 100 pages free, and charge reproduction costs for the remainder. Copies cost \$.15 per page and microfiche costs \$.25 per fiche. If you have documentation showing the patient was previously provided a copy of his/her medical record at no charge, charge a fee for subsequent copies of the same records already copied. If the patient requests copies of records which were added to the file after the first copy was provided, don't charge for those copies if under 100 pages.

1.3.6.2. According to AFI 33-332, [chapter 4](#), paragraph [4.3](#), fees are not charged for the following: When the requester can get the record without charge under another publication (for example, medical records); for search; for reproducing a document for the convenience of the Air Force; and for reproducing a record so the requester can review it.

1.3.7. Advance payments for information requests from insurance companies and other agencies may be accepted. If the request is for a large volume or requires extensive research, notify the requester of any additional charges.

1.3.7.1. If the payment is incorrect, inform the requesting agency that the information is being provided even though the required fee (specify amount) has not been paid, to avoid possible adverse effect to the patient. Advise the requester to send payment promptly to the medical service account (MSA) by check or money order payable to the Treasurer of the United States.

1.3.7.2. Send payment to the MSA office with the completed copy of the transmittal letter (see paragraph 1.4.1.) if correct payment is received with the request. If the information cannot be obtained on the day the request is received, complete only the required items and send the form and payment to the MSA before the ordinary close of business each day.

1.4. Releasing Information to Certain Persons and Agencies.

1.4.1. **THIRD PARTY OR INSURANCE AGENCY:** When releasing information to Third Party or Insurance Agencies, use either a locally developed transmittal letter or the form furnished by the requester. Prepare the transmittal letter or form in three copies; send the original to the requester, file the second copy in the health record with the authorization for release of information, and forward the third copy to the MSA officer. When answering requests for information on injury cases which appear to involve third party liability action, send a copy of the letter or form to the SJA.

1.4.1.1. Annotate the locally developed transmittal letter to reflect the documents enclosed when sending specific documents instead of extracting information. Send a copy of the reply to the MSA officer when fees are involved.

1.4.1.2. Include this statement in the transmittal letter: “You are not authorized to release this information to any party without the permission of the patient, his/her legal representative, or this medical facility.”

1.4.1.3. Any requests identified as a potential third party liability case must be recorded on an AF Form 1488, **Daily Log of Patients Treated for Injuries**. This includes requests received from an attorney, worker’s compensation appeals board, or an insurance company in a case involving work-related injury or disease.

1.4.2. **PATIENT OR AUTHORIZED REPRESENTATIVE:** Information may be released directly to the patient or authorized representatives of the person concerned upon receipt of a written request from the patient (or legal representative). An abstract of the case (or copies of pertinent pages of the record) may be furnished to the person, or authorized representative when a person departs on a temporary absence from home and requires medical care while away.

1.4.2.1. If a physician determines that direct disclosure to the patient could have an adverse effect on either the physical or mental health, safety, or welfare of the individual, or other persons with whom he/she may have contact, the disclosure will be made to a health care provider named by the individual, or to a person qualified to make psychiatric or mental determinations. See AFI 33-332, para 4.4.2 for additional guidance.

1.4.2.2. Give civilian employees and military members and their designated representatives access to their health records upon written request. The original record is retained at the MTF, but copies will be provided if requested. If access cannot be provided within 15 days after the request, state the reason for the delay and the earliest date when the records will be available.

1.4.2.2.1. Encourage health care providers to discuss with employees the contents of their health records. Health care providers may recommend ways of disclosing health records other than by direct employee access. When appropriate, a health care provider can elect to disclose information on specific diagnoses of terminal illness or psychiatric conditions only to an employee’s designated representative, and not directly to the employee.

1.4.3. RECORDS OF NEWBORNS RELEASED FOR ADOPTION: Take special care releasing information from the records of newborns who have been released for adoption. Delete all references to the child's natural parents. Stamp the inpatient record folders of these newborns, "Release of Information Restricted according to AFI 41-210, Chapter 1, para 1.4.3." Do not forward AF Form 560, AF Form 565, **Record of Inpatient Treatment**, SF 502, **Medical Record - Narrative Summary (Clinical Resume)**, or SF 535, **Medical Record - Newborn** included in the outpatient record.

1.4.4. RELEASE TO THE PUBLIC: Always consult the SJA prior to releasing medical information to the public. Only information which does not constitute a clearly unwarranted invasion of personal privacy is made available to the public, including the news media. If appropriate, notify the next of kin before releasing information to the news media or the public.

1.4.4.1. The following information may be released WITHOUT the patient's consent: name and rank (if applicable), component occupation or job title, and present medical assessment of condition (i.e., stating condition stable, good, fair, serious, or critical). Office and unit assignment for personnel not assigned to routinely deployable or sensitive units may be released without the patient's consent.

1.4.4.2. The following information CANNOT be released without the patient's consent: marital status (e.g., married or unmarried), base, station or organization of routinely deployable or sensitive units, description of disease or injury, general factual circumstances and general extent of the injury or disease. Do not specify location or description that may prove embarrassing to the individual or reflect bad taste.

1.4.4.3. Do not presume consent; instead, follow these rules:

1.4.4.3.1. Do not release information regarding medical assessment (para 1.4.4.1.) when a conscious and competent patient objects to the release of the information.

1.4.4.3.2. Do not release information listed in para 1.4.4.2. if the patient is not conscious or is mentally incompetent. If the patient is incompetent, the guardian may make the decision.

1.4.4.4. More specific medical information may be provided by the health care provider if approved by the patient or guardian.

1.4.4.5. NEVER release a prognosis or sensitive medical information relating to the admission of the patient, such as sexual assault, criminal actions, drug or alcohol abuse, psychiatric or social conditions, venereal disease, or Acquired Immunodeficiency Syndrome (AIDS) – HIV (Human Immunodeficiency Virus) data or AIDS related syndrome. **NOTE:** In all cases in para 1.4.4.3 and 1.4.4.5, make the statement "Further details with regard to (individual's) admission to the hospital are not releasable at this time."

1.4.4.6. Consult the SJA for assistance with problems relating to the release of information.

1.4.5. DoD INVESTIGATIVE AGENCIES: Special agents are granted access to health records when proper identification is provided. The agent must sign a dated statement which contains the identity of the record to be examined, the identity (file number) of the investigation for which the record is being examined, a certification by the examiner that the examination is required as part of the official investigation, identification of any copies of material furnished to or copied by the agent, and a signed receipt. (NOTE: Do not file the statement in the patient's health record. Maintain the statement in a separate folder in the general correspondence files. Dispose of in accordance with AFI 37-139, *Records Disposition Schedule*, Table 37-11.

1.4.5.1. Although the OSI has the right to seize Government records for investigation, OSI agents will not seize original medical records without SJA coordination. If such coordination is received, copies of the seized records will be left with the medical facility. In all but very few exceptions, giving the OSI a certified true copy of the original records will suffice. Consult with the SJA if questions arise.

1.4.5.2. Special agents should seek an interview with a health care provider when clarification or interpretation of medical documentation is necessary.

1.4.6. LITIGATION CASES: Refer requests for release of medical information required for pending litigation to the SJA for advice or action.

1.4.7. GOVERNMENT DEPARTMENTS AND NON-DOD AGENCIES: Medical information is released upon request, to other departments and agencies, both Federal and State, that have a proper and legitimate need for the information. For example, release information to:

1.4.7.1. The Department of Veterans Affairs or Office of Workers Compensation Programs to process a claim in which the person's medical history is relevant.

1.4.7.2. Federal and State hospitals and prisons for further medical treatment of a person in their custody.

1.4.7.3. The Occupational Safety and Health Administration to help detect, treat, and prevent occupational injuries and diseases.

1.4.7.4. Air Force Reserve or Air National Guard (ARC) medical personnel when required to determine the medical qualification for continued military duty of a spouse or other beneficiary who is a Reservist or Guardsmen.

1.4.8. RESEARCH PURPOSES: Release medical information upon the request of medical research or scientific organizations or other qualified researchers when, in the opinion of the releasing authority, its release is legal and in the public interest. This also includes release of information to present or former members of the armed forces who need it for private study or research to advance their professional standing. Do not release the information if it violates existing laws.

1.4.8.1. Medical records used for research will not be removed from the MTF or other facility; space and facilities will be furnished by the record custodian. Access may be granted to records in MTFs and facilities of the General Services Administration (e.g., National Personnel Record Centers (NPRC)). Where possible, names and SSNs of individuals are deleted from copies.

1.4.8.2. MTF Commanders will approve requests from personnel under their command whose research projects involve medical records maintained at that facility.

1.4.8.3. Submission of research requests. With the exception of requests falling under the guidance in para 1.4.8.2, all requests from outside and within the Department of the Air Force will be made through channels to AFMOA/SGOI, 2510 Kennedy Circle Ste 208, Brooks AFB, TX 78235-5121.

1.4.8.4. Requests will include the following:

1.4.8.4.1. Name and address of researcher and any assistants.

1.4.8.4.2. List of the professional qualifications of the researcher and any assistants.

1.4.8.4.3. Description of the researcher's project or field of study.

1.4.8.4.4. Reason for requesting the use of Air Force records.

1.4.8.4.5. Identification of the specific records required and their location.

1.4.8.4.6. Provide inclusive dates when access is desired.

1.4.8.4.7. Signed agreement from each person named in the request listing the following conditions:

1.4.8.4.7.1. Information taken from Air Force medical records will be treated according to the ethics of the medical and dental profession.

1.4.8.4.7.2. Identities of people mentioned in the records will not be divulged without their written authorization, and no photographs of a person or of any exterior portion of his or her body will be released without his or her written consent.

1.4.8.4.7.3. The researcher understands that permission to study the records does not imply approval of the project or field of study by the Air Force Surgeon General.

1.4.8.4.7.4. All identifying entries concerning a person will be deleted from abstracts or reproduced copies of the records. Published reports will not identify in any way individuals whose health records were examined.

1.4.8.4.7.5. Any published material or lectures on the particular project or study will contain the following statement: "The use of Air Force medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Air Force approval of the conclusions presented."

1.4.8.5. Proof of access authorization: Any approval letter from the Surgeon General allowing access to records will be shown to the proper authority (custodian of the medical records) when requesting access to records at the MTF level.

1.4.9. ACCESS TO ACTIVE DUTY MEMBER HEALTH RECORDS BY COMMANDERS OR COMMANDER REPRESENTATIVES.

1.4.9.1. The Privacy Act, 5 U.S.C 552a, contains an exception in section (b)(1), which provides for disclosure to "those officers and employees of the agency which maintains the record who have a need for the record in the performance of their duties."

1.4.9.2. Access, however, must be balanced with the recognized sensitivity of medical records, which often contain information of a very private nature. Therefore, before a Commander or First Sergeant gains access to an individual's health record, he or she must establish a clear and compelling need for those records.

1.4.9.3. The MTF Commander provides a summary of the pertinent records to PRP certifying and reviewing officials at their request. A request from or the consent of the individual concerned in the review is not required (See 5 U.S.C. 552a[b]1).

1.4.9.4. The actual record will be provided only if specifically requested for clarification purposes or other expressed compelling need. For actual records release in this section, the requester shall document in writing to the MTF Commander the need for the actual record, and why a summary per paragraph 1.4.9.3 is not sufficient.

1.4.9.5. The requester should seek the assistance of a physician to interpret the terminology in the record, if a summary will not suffice.

1.4.9.6. PRP certifying and reviewing officials must not release or discuss the medical records except as directed in this section.

1.4.9.7. Nonmedical PRP certifying officials and reviewing officials are authorized to review medical records of candidates and members of the PRP to make determinations required by DoD Directive 5210.42. In accordance with DoD Directives 5400.7 and 5400.11, medical records may be disclosed to reviewing and certifying officials for this purpose without either a request from or the consent of, the individuals to whom those records pertain. Because of the sensitive and confidential nature of the records, review authority shall extend only to the reviewing and certifying officials and designated inspectors. When appropriate, such review shall be conducted with the assistance of a physician who can advise on medical record data that might otherwise be misinterpreted.

1.5. Sending/Receiving Medical Information via Telefax, Electronic Mail(E-Mail) or Other Similar Methods.

1.5.1. Although most regulatory and accreditation requirements do not specifically address the use of Telefax in relation to transmission of health information, you must be aware of any specific state laws and regulations, including hospital licensure laws, which address requirements for original records or facsimile transmission.

1.5.2. Previously listed guidelines pertaining to the release of information apply regardless of the method of release.

1.5.3. To protect patient privacy, only use facsimile transmission when the original record or mail-delivered copies will not meet requirements for immediate patient care. Only telefax sensitive information when urgently needed for patient care or when required by a third-party payor for ongoing certification of payment for a hospitalized patient.

1.5.4. Limit facsimile or transmission to only that documentation necessary to meet the requester's needs. Utilize regular mail or messenger service for routine disclosure of information to insurance companies, attorneys or other legitimate users.

1.5.5. The cover letter sent with the documentation transmitted will include (See [figure 1.1](#)):

1.5.5.1. Date and time of facsimile transmission

1.5.5.2. Sending facility's name, address, telephone and facsimile numbers

1.5.5.3. Sender's name

1.5.5.4. Receiving facility's name, address, telephone and facsimile numbers

1.5.5.5. Authorized receiver's name

1.5.5.6. Number of pages transmitted including cover page

1.5.5.7. Confidentiality notice, including instructions on redisclosure and destruction

Figure 1.1. Sample Format –Facsimile Cover Letter.**FACSIMILE COVER LETTER**

[sending facility name]

[address]

[city, state, zip code]

[telephone number]

[facsimile number]

DATE: _____ TIME: _____ NO. OF PAGES: _____

TO: _____ (name of authorized receiver)

(name and address of authorized receiver's facility)TELEPHONE: _____ FAX: _____
(of receiver) (of receiver)

FROM: _____ (name of sender)

TELEPHONE: _____ FAX: _____
(of sender) (of sender)

COMMENTS:

*******CONFIDENTIALITY NOTICE*******

The documents accompanying this telefax contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telefax in error, please notify the sender immediately to arrange for return of these documents.

Note: This is a sample form. It should not be used without review by your organization's legal counsel to ensure compliance with local and state laws.

1.5.6. Maintain the signed release authorization and the original cover letter with a notation of the disclosed information, date and identity of the employee making the disclosure. File these in the patient's health record.

1.5.7. If the documentation is received by anyone other than the intended recipient, the burden is on the sender to remedy that error. Frequently used destination numbers should be preprogrammed into the telefax machine to eliminate misdial errors.

1.5.8. If the transmission does not reach the intended recipient's system, check the internal logging system of the facsimile machine to determine where the transmission was sent. Send a request to the incorrect number explaining that the information was misdirected and asking for return of the documents via mail. See [figure 1.2](#) for a sample cover letter to accompany the request. Notify the Risk Management department and follow their instructions for any other action to take.

Figure 1.2. Sample Format—Misdirected Facsimile Cover Letter.**MISDIRECTED FACSIMILE COVER LETTER**

[sending facility name]

[address]

[city, state, zip code]

[telephone number]

[facsimile number]

DATE: _____ TIME: _____ NO. OF PAGES: _____

TO: Recipient at 999/999-9999

FROM: _____

(name of sender)

TELEPHONE: _____

(of sender)

FAX: _____

(of sender)

COMMENTS:

We believe that information on one of our patients was transmitted to you in error. This is confidential information, belonging to *[name of sender]* that is legally privileged. Please return these documents to us immediately by mail. Thank you.

*******CONFIDENTIALITY NOTICE*******

The documents accompanying this telefax transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telefax in error, please notify the sender immediately to arrange for return of these documents.

Note: This is a sample form. It should not be used without review by your organization's legal counsel to ensure compliance with local and state laws.

1.5.9. The receiver of the documentation is bound by all of the laws and requirements governing the use and release of medical documentation.

1.5.10. To help protect confidentiality, establish specific policies and procedures for handling documents received via facsimile. Include the following:

1.5.10.1. Identify one individual, if possible, to monitor the facsimile machine

1.5.10.2. Remove documents as soon as the transmission completes

1.5.10.3. Count pages to ensure transmission of all intended information. Check for legibility and notify sender of problems

1.5.10.4. Read the cover letter and comply with instructions for verifying receipt

1.5.10.5. Process the documents, if appropriate, or notify the authorized recipient that a facsimile transmission has been received. Seal the documents in an envelope and deliver to the authorized recipient or hold for pickup

1.5.11. Unless otherwise prohibited by state law, documentation received via facsimile can be included in the patient's health record.

1.5.12. The use of facsimile to transmit physician's orders is permissible. To verify their authenticity, the provider should sign the orders prior to transmission. If the orders were not signed, do not carry them out until the ordering physician verifies them. Unless otherwise required by state law or regulation, the facsimile copy does not require countersignature.

1.5.13. Documentation transmitted on thermal paper will fade over time. Make a photocopy of the document and place that copy in the record. Destroy the thermal paper document after making the photocopy.

1.5.14. See AFI 33-119, *Electronic Mail (E-Mail) Management and Use*, for guidelines to use when sending privacy information via E-mail.

1.6. Power of Attorney.

1.6.1. The Staff Judge Advocate provides the rules regarding the need for a sponsor or patient to get a power of attorney. Ensure all hospital and clinic personnel are made aware of the power of attorney rules.

1.6.2. Call the base SJA or medical law consultant at the nearest medical center on unusual cases.

Chapter 2

WORKING WITH HEALTH RECORDS

2.1. Documenting Health Records. Health care providers document all services performed in a permanent health record. Inpatient records, Mental Health, and Ambulatory Procedure Visit (APV) records complement outpatient records so that together they provide a complete account of the treatment provided to an individual. Health records are completed to meet the highest possible standards of completeness, promptness, clinical pertinence, and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Dental records are the responsibility of the base dental surgeon. See AFI 47-101, *Managing Air Force Dental Services*, for maintenance of dental records.

2.2. Managing Health Records.

2.2.1. Health records are the property of the United States Government, not the individual. Maintenance of records at the military treatment facility is required. Inform beneficiaries of this requirement through appropriate media. Initiate action to retrieve records maintained outside the MTF.

2.2.2. The MTF Commander is the custodian of outpatient and inpatient records. The Dental Surgeon is the custodian of the dental records and is responsible to the Commander for that area. Each MTF Commander will ensure health records are protected and controlled, release of medical information is appropriate, and provider's documentation is thorough. The MTF Commander will also manage assurance of paper-based and computer-based medical records.

2.2.3. Identify the MTF having custodial responsibility for the outpatient record with a self-adhesive label affixed to the health record folder in the lower right-hand corner.

2.2.4. A Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), or Air Force member with equivalent education and experience, manages the inpatient records department and medical transcription. The RHIA or RHIT is credentialed by the American Health Information Management Association and is a civilian rated eligible by the Office of Personnel Management Qualification Standard for the GS 669 series. The RHIA or RHIT works directly with the chief of the medical staff. This individual also works closely with the Information System Security Office (ISSO) to ensure security and controlled access to both the paper-based and automated medical records.

2.2.5. Records created and maintained at a joint Department of Defense/Veterans Administration (DoD/VA) facility are shared by the two organizations. Develop local policies to ensure that the needs of both organizations are met. Follow the instructions in AFMAN 37-139 for disposition of records to the National Personnel Record Center (NPRC) in St. Louis, MO.

2.3. Correcting Health Records. Attachment 2 provides specific guidance for correcting health records when entries in a health record are in error.

2.4. Reviewing Health Records.

2.4.1. Record review functions are performed at each MTF to evaluate the quality, clinical pertinence, information assurance, and timely completion of inpatient and outpatient records and to ensure they are prepared and maintained according to Air Force directives and JCAHO standards. These func-

tions are performed by representatives of the various clinic services, dental services, nursing services, inpatient record departments and other departments, as appropriate. Forward written reports to the appropriate MTF oversight committee for review.

2.4.2. Functions tasked with records review must approve overprinted Standard Forms (SF) filed in health records. SAF/AAIP granted a waiver to AFI 37-160, volume 8, *The Air Force Publications and Forms Management Programs—Developing and Processing Forms*, permitting overprinting on SFs. This waiver concerns overprinting only and does not grant authority to reprint existing SFs at the local level. Overprints are authorized only when the material added does not conflict with the purpose for which the form was intended. See AFI 37-160, volume 8, for further instructions on the authorized use of overprinted forms.

2.5. Preparing and Filing Health Records. Preparation of folders, arrangement of content, and record filing methodology is consistent throughout Air Force medical treatment facilities. See [attachment 3](#).

2.6. Management of Inpatient Records Created at Deployed Air Transportable Hospitals (ATH) and Contingency MTFs:

2.6.1. The tactical medical facility maintains the inpatient records while deployed. Upon return of the facility to home base, give these records to the inpatient records section at the parent facility for maintenance as a separate record group. DO NOT send the records to the MTF where the member is based, if different than facility's parent unit. The home base will retire the records in accordance with AFMAN 37-139.

2.6.2. Treat records created at Military Operations Other Than War (MOOTW), i.e., contingency facilities, similarly to guidance included in paragraph 2.6.1. At those facilities where the management rotates between the three military Services and also between the Air Force medical treatment facilities, maintain the records until the management rotates (either to another Air Force medical treatment facility or another Service). Upon rotation of management, return the records to the parent unit's inpatient record department for maintenance as a separate record group. DO NOT send the records to the MTF where the member is based, if different than facility's parent unit. The parent unit will retire the records in accordance with AFMAN 37-139.

2.6.3. Fixed contingency facilities maintained solely by the Air Force maintain and retire records the same as any other fixed MTF. Those facilities deployed for an extensive period of time may request a waiver for early retirement of inpatient records to the NPRC. See paragraph 2.12.1.2.

2.7. Management of Outpatient Records Pre and Post Deployment. The original medical records on deployed active duty and ARC personnel will remain at the home base MTF. Prior to deployment, photocopy the DD Form 2766 or AF Form 1480A (whichever form is in the record) and keep the copy in the original medical record. The original DD Form 2766 or AF Form 1480A will be sent with the individual as outlined in [attachment 3](#), Section A3.5.3. For individuals on PRP, a copy of AF Form 745, **Sensitive Duties Program Record Identifier** will be placed in the DD Form 2766 or AF Form 1480A upon deployment. Stamp "PRP" in 2-inch letters on the cover of the DD Form 2766 or AF Form 1480A when individual is deployed.

2.7.1. Records will be maintained and managed (to include information assurance) by the MTF in the area of operation responsible for providing primary medical care to the member. Utilize the guidelines in [chapter 4](#) and [attachment 3](#), as applicable.

2.7.2. Deployed records will be managed to ensure that all medical documentation is captured and that the documentation is returned for filing in the original medical record once the member returns to the MTF. If the deployed member receives medical care or testing, all medical documentation is placed in the bracket inside the DD Form 2766 or AF Form 1480A folder (e.g., SF 600, **Medical Record – Chronological Record of Medical Care**, AF Form 422, **Physical Profile Serial Report**, ancillary reports, etc.)

2.7.3. When the member returns to the home base after deployment, ensure that the deployed record is returned to the home base MTF.

2.7.4. Upon return of the member to the home base (after deployment), remove the medical documentation (except for the DD Form 2766c) from the DD Form 2766 or AF Form 1480A folder and place it in the proper order within the patient's medical record (See A3.4.) Also file the DD Form 2766 or AF Form 1480A in the medical record. Remove and shred the photocopied DD Form 2766 or AF Form 1480A upon filing the original in the medical record.

2.8. Management of Records for Personnel in the Nuclear Weapons Personnel Reliability Program (PRP): Medical records for individuals on PRP require special handling to maintain the integrity of the program. Instructions for special preparation of PRP records is located in A3.2.1.5 and A3.4.2.1.1. PRP program requirements may be located in AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*.

2.9. Automation of Health Records. The Military Medical Health Service System is transitioning from a health record in paper format to a computer-based patient record system. Automated health data and record systems are a part of the overall military health records system and are protected under the Privacy Act of 1974. Computer-based patient records, at a minimum, must meet the same standards and guidelines as the paper-based record. They must also meet required data security and medical privacy rules under the HIPAA Act of 1996. Until such time as a completely computerized medical record is available, mechanisms must be in place to ensure electronic information is hardcopied when patients are referred for further medical care, separating, retiring or being discharged from the military, transferring to another duty station, or if the archived record is about to expire.

2.10. Documentation of Telemedicine. In order to provide a uniform approach to the documentation of telemedicine, these guidelines are proposed:

2.10.1. Patient must provide written consent before encounter is videotaped.

2.10.2. Written documentation of consultation by providers at both ends of encounter.

2.10.3. Permanent video images will be erased after written documentation is complete. (Exception: cases with exceptional educational value. Any MTF which chooses to keep images on file for educational purposes should have a standard operating procedure or policy on how the images will be maintained. Review this guideline periodically and update as necessary.)

2.10.4. Final documentation by provider will indicate whether or not the image was erased.

2.10.5. Duration of storage of videotaped images is not yet defined, but the Department of Veterans Affairs must store all medical records of military members for 75 years.

2.10.6. There is currently no clear medicolegal determination on whether a videotaped procedure or consultation will become part of the patient's medical record. Contact the medical law consultant for the most recent guidelines.

2.10.7. The decision on whether or not to retain the videotaped image must be carefully made. If videotapes are available for some patients but not for all, absence of a videotape may create the perception of purposeful destruction of evidence.

2.11. Disposition (Transfer or Retirement) of Records to National Personnel Records Center (NPRC), the Department of Veterans Affairs (DVA) or the Civilian Personnel Office (CPO).

2.11.1. Health record groups (outpatient and dental record) along with a photocopy of the DD Form 214, **Certificate of Release or Discharge from Active Duty** and the DD Form 2697, **Report of Medical Assessment**, for active duty members separating, retiring or being discharged **after** 1 May 94 are transferred to the DVA, Records Management Center, P.O. Box 5020, St. Louis, MO 63115-0020 (Reference AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*, para 2.20.1). NOTE: For members separated, retired or discharged before 1 May 94, follow the guidance in paragraph 2.11.3. for retirement of outpatient records to NPRC.

2.11.1.1. For those members separating under Palace Chase or Palace Front, send the records to the gaining reserve or guard unit.

2.11.1.2. If the member is filing a claim for disability at the time of separation, send the records to the Veterans Administration Regional Office (VARO) of the state where the member intends to reside. (NOTE: A new policy encourages individuals **prior** to separation or retirement to set up an appointment through the Veterans Administration for physicals and disability processing. Individuals should take their records to these appointments which will probably be occurring in the area from which they are retiring.)

2.11.1.3. Within 5 workdays after the member's Date of Separation (DOS), the MTF will forward the records and any loose documentation to the Military Personnel Flight. If this is not accomplished within the time frame, the MTF is responsible for forwarding the records to the appropriate office within the military or the DVA (as stated in this section). NOTE: Any loose documentation must be placed into an outpatient folder before it is forwarded.

2.11.2. Outpatient records of allies and neutral military personnel are disposed according to AFMAN 37-139, *Records Disposition Schedule*, Table 41-12, Rules 8-8.01.

2.11.3. Outpatient records of non-military and retired military personnel are retired to the NPRC in St. Louis, MO at the end of each calendar year in accordance with AFMAN 37-139, Table 41-12, Rules 2-9.01.

2.11.3.1. Screen records according to the date of last treatment. Records are maintained at the MTF for two years after the year in which the last treatment occurred and then retired. This does not pertain to medical records on ARC members which are being maintained by MTFs. Contact the appropriate POC at the ARC unit for disposition instructions when a question exists on whether or not an ARC member is still actively participating. If a local POC is unknown, then contact the appropriate ARC/SG (see Section C—Terms for disposition instructions).

2.11.3.2. Exceptions to the guidance in para 2.11.3.1 are identified in 2.11.3.2.1 and 2.11.3.2.2. However, when processing these records for retirement, those retained beyond the normal retire-

ment date must be separated by the year in which they should have been retired. If the amount of records is minimal (i.e., amount allows easy interfiling with boxes already archived at NPRC), ship to NPRC under separate cover annotated with the same accession number, year group, location number and box number of the proper retirement location where records from that retirement period were previously sent to NPRC (information retrieved from appropriate SF 135, Records Transmittal and Receipt). If the amount of records will not allow interfiling, the MTF must prepare new SFs 135 requesting accession numbers (i.e., prepare these records for retirement the same as any other series of record being retired.)

2.11.3.2.1. If the sponsor is still assigned to the base, records of eligible family members should be retained if the family is still in the area, even if they did not receive care during the year.

2.11.3.2.2. Retain the outpatient records for an entire family as long as one family member is receiving medical care.

2.11.4. Maintain outpatient records of civilian Air Force employees until the employee is transferred to another activity within the Federal government or is separated from the Federal Service. Upon transfer or separation, place the record in SF 66D, **Employee Medical Folder**, and forward the record to the Civilian Personnel Office.

2.11.5. Inpatient records of all personnel are retired to NPRC in St. Louis, MO, in accordance with AFMAN 37-139, Table 41-11, Rules 1-15. They are retired according to the year of discharge. MTFs without established Medical Record Libraries retire records 1 year after the year of last discharge (i.e., 1997 records will be retired in 1999); those MTFs with established Medical Record Libraries retire records 5 years after the year of last discharge unless a waiver has been granted by the National Archives and Records Administration.

2.11.5.1. Inpatient records created during the deployment of Air Transportable Hospitals (ATH) are maintained by the ATH until it returns to base. Follow the same procedures for retirement of the records to NPRC as listed in para 2.11.5. If the ATH remains deployed for several years, the records are maintained there until retired to NPRC. A waiver request for early retirement can be submitted (See paragraph 2.12.1.1.)

2.11.5.2. Inpatient records created during the management of contingency medical treatment facilities are maintained at that facility until either management of the facility is transferred to another Service (i.e., Army or Navy) or the time period for maintaining inpatient records has lapsed. Follow the same procedures for retirement of the records to NPRC as listed in para 2.11.

2.11.6. The rules for retirement of Extended Ambulatory Records (EAR) to the NPRC in St. Louis, MO, are the same as those for inpatient records. Follow the guidelines in AFMAN 37-139. The EAR will be retired to NPRC along with the inpatient records. If space allows, the EAR folder will be drop filed inside the inpatient record folder. If space does not allow, the EAR folder will be placed behind the inpatient record folder as if it were a second volume of the inpatient record. If the patient does not have an inpatient record but does have an EAR, the EAR will still be included in the shipment of inpatient records. Be sure to annotate the shipping log that the shipment contains both inpatient and EAR records. See paragraph 4.5 for instructions regarding the type of documentation included in the EAR folder.

2.11.7. Fetal monitoring strips are retired to NPRC in accordance with AFMAN 37-139, Table 41-11, Rules 21 and 21.01. NOTE: Digitized, or other format, fetal monitor strips which can be printed out

are filed in the infant's inpatient record or the mother's if the infant is stillborn. These are retired as a part of the inpatient record.

2.11.8. A SF 135, **Records Transmittal and Receipt**, or CHCS electronic equivalent, is prepared for each series of records being retired to NPRC. Follow the guidelines in AFI 37-138, *Records Disposition – Procedures and Responsibilities*, Chapter 6, Records Disposition - Procedures and Responsibilities, for completion of the form and preparation of the records for shipment. Maintain the SF 135 returned from NPRC annotated with the accession number, location number and box number for future use. This information is invaluable when retrieving records from NPRC or retiring retained records. According to Table 37-19, Rules 3-7 of AFMAN 37-139, the SFs 135 will be maintained and only destroyed when all records listed have been destroyed or transferred to the National Archives, or when no longer needed, whichever is later.

2.11.9. Civilian Employee Medical Folder (EMF) is a chronological, cumulative record of occupational and nonoccupational information pertaining to the health of a civilian employee during the course of employment. This record consists of personal and occupational health histories, exposure records, medical surveillance records, Office of Worker's Compensation Programs (OWCP) records, and the documented notes, evaluations and tests results generated by health care providers in the course of examination, treatment and counseling.

2.11.9.1. Forward to the Military Personnel Flight (MPF), Civilian Personnel Section, the EMF of any employee transferring to another Federal agency or separating from Federal service within 10 days of transfer or separation. It is the responsibility of the MPF to forward the EMF to the appropriate custodian.

2.12. Base Closures and Medical Records Management.

2.12.1. Inpatient Records are retired to the NPRC upon inactivation of the clinical records library or hospital (or upon downsizing to a clinic) in accordance with AFMAN 37-139, Table 41-11.

2.12.1.1. If early retirement is desired (i.e., out of cycle), the MTF Commander must request early retirement from HQ USAF/SCMI, 1250 Air Force Pentagon, Washington, DC 20330-1250. Coordinate the request with the local Information Management Office before submission.

2.12.1.2. Requests for early retirement must be submitted as soon as possible because of the time required for approval. The request is coordinated with NPRC who will notify the MTF Commander of the decision. The request must include the following:

2.12.1.2.1. Reason for request

2.12.1.2.2. Closure date (or date realigning to a clinic)

2.12.1.2.3. Type(s) of records to be retired

2.12.1.2.4. How many records (volume) involved

2.12.1.2.5. All information normally included on the SF 135 when requesting an accession number from NPRC

2.12.2. Outpatient records of active duty members and their family members are transferred to the member's gaining base in accordance with guidance in [attachment 6](#), para A6.8.

2.12.3. Outpatient records of retirees and others.

2.12.3.1. If another MTF is identified by the patient as the new facility of treatment, forward the medical records to that facility with a cover letter explaining why the records were forwarded.

2.12.3.2. If a civilian medical treatment facility is identified as the new treatment facility, copy pertinent portions of the record for the patient to take to that facility. Retire the original record to NPRC in accordance with AFMAN 37-139. Maintain an AF Form 1942, **Clinic Index**, for six months or until the base closes, whichever comes first, then destroy.

2.12.4. For sequestered records, each Major Command (MAJCOM) will designate repository bases within the command to administer medical records involved in projected or actual litigation.

2.12.4.1. If an actual medical malpractice claim was filed for active duty family members, forward the original inpatient or outpatient record (as applicable) to the Risk Manager or Hospital Administrator at the gaining MTF. **Do not** allow the patient to handcarry the record. In addition, send a letter explaining why the records are being forwarded and include the appropriate accession number, year and location in which the records should have been retired to NPRC. This information will enable the gaining MTF to appropriately retire the record when the claim is settled.

2.12.4.2. If an actual medical malpractice claim was filed for a retiree or other patient and the continued care will be provided at an Air Force medical treatment facility, forward the original record with the appropriate letter of explanation as mentioned in para 2.12.4.1. If the care will be provided by a civilian or non-Air Force medical treatment facility, provide the patient with a copy of the record and forward the original with the appropriate letter to the Risk Manager or Medical Facility Administrator at the designated repository.

2.12.4.3. If there is a potential claim in reference to inpatient records, forward the original inpatient record with the accompanying letter of explanation to the Risk Manager or Quality Services Manager at the gaining Air Force medical treatment facility or designated repository base.

2.12.4.4. If there is a potential claim in reference to outpatient records, as a general rule, follow procedures outlined in this section. Coordinate special concerns and circumstances with the local base Staff Judge Advocate.

2.12.5. Closure bases must establish a "Chain of Custody" document which lists each patient's name, SSN and location to which the medical record was forwarded. Forward a copy of the Chain of Custody document to the MAJCOM.

2.12.6. On inactivation of the MTF, the SF 135s will be forwarded to the next higher records management office (i.e., the MAJCOM).

2.13. Requests for Medical Records. When requesting records from NPRC utilize the DD Form 877-1, Request for Medical/Dental Records from the National Personnel Record Center (NPRC) (St. Louis, MO). This form contains space for the information required by NPRC to institute a search for the requested record. When requesting records from another MTF, utilize the DD Form 877, **Request for Medical/Dental Records or Information**, or some other form as desired.

Chapter 3

ADMINISTRATION OF PATIENTS

3.1. Quarters Status : Quarters is a full duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care. A quarters patient is treated on an outpatient basis, permitted to remain at home or in quarters, and is generally returned to duty within a 72-hour period.

3.1.1. Establish local procedures for program management, including:

3.1.1.1. Notifying patient's commander/first sergeant. (Notify the ARC commander/First Sergeant when Reservist or Guardsmen require this action.)

3.1.1.2. Notifying Military Public Health for communicable disease tracking.

3.1.1.3. Reporting data to Resource Management.

3.1.1.4. Extending period of quarters.

3.1.2. Other restrictions: Physician assistants/nurse practitioners may not place a patient on quarters for longer than 48 hours without approval by a physician. OB quarters is discussed in AFI 44-102, *Community Health Management*.

3.2. Line of Duty (LOD) Determinations: The attending health care provider decides when an LOD determination is required (see AFI 36-2910, A2.1). An LOD determination is required in death cases when the member dies leaving family members. Initiate LOD on AF Form 348, **Line of Duty Determination**.- Notify HQ ARPC/DRSP, DSN 926-6134, on all LOD determinations initiated on participating Individual Reservists.

3.2.1. In cases where the health care provider has determined a LOD is required for an admission, the admitting clerk obtains the time, place, and manner of occurrence of the incident from the patient or other witness and records the information on the reverse of the AF Form 560.

3.2.2. Full instructions for making LOD determinations (including preparation of the AF Form 348) are available in AFI 36-2910, *Line of Duty (Misconduct) Determination*. Use AFI 36-2910/AFRC Supplement when initiating LODs on Reserve personnel.

3.3. Utilizing the AF Form 570, Notification of Patient's Medical Status for Special Administrative Actions: Use AF Form 570 when:

3.3.1. Reporting communicable diseases.

3.3.2. Reporting patient injuries that occur after admission.

3.3.3. Reporting anticipated Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) action.

3.3.4. Indicating probable hospitalization over 90 days.

3.3.5. Reporting deaths to patient administration or the administrative officer of the day (AOD).

3.3.6. Reporting Very Seriously Ill, (VSI), Seriously Ill (SI), or Incapacitating Illness or Injury (III) patients or removing from or movement between these categories.

3.3.7. Reporting any information about a patient's medical status requiring administrative action.

3.4. Electing Optional Civilian Medical Care : Air Force members must notify the servicing MTF within three days of treatment when receiving civilian medical care at his/her own expense (i.e., in such cases specified in AFI 41-101, *Obtaining Alternative Civilian Medical and Dental Care*, para 1.4). Collect information on the nature of the ailment or illness, treatment received or recommended and any drugs or medication prescribed, and file it in the medical record.

3.4.1. Ordinary leave for lost time may be required in accordance with AFI 36-3003, *Military Leave Program*. Note: If a member elects childbirth from civilian sources at her own expense (hospitalization or home delivery), she must take ordinary leave to cover any period of time lost from duty before delivery. The attending provider recommends convalescent leave in accordance with AFIs 36-3003 and 44-102.

3.4.2. Patient must arrange for the civilian medical facility to send a summary of treatment to the servicing MTF.

3.4.3. Approved organ donors hospitalized in civilian facilities will be considered administrative inpatients. Convalescent leave may be granted by the patient's commander in accordance with AFI 36-3003.

Chapter 4

AMBULATORY PATIENT ADMINISTRATION

4.1. General Information. Outpatient records must contain enough information to identify the patient, support the diagnosis, justify the treatment, and accurately document the results of care rendered.

4.1.1. If a beneficiary has received medical care under two different social security numbers (SSN), as a result of remarriage to another military sponsor, record forms filed under the former SSN should be brought forward to the SSN currently in the Defense Enrollment Eligibility Reporting System (DEERS). For future inquiries, a cross-reference from the old number to the new number should be indicated in the outpatient files as well as in the current automated system.

4.1.2. If a beneficiary has received medical care under two different SSNs as the result of dual eligibility status (person eligible for care as family member of active duty, ARC member, or as a retiree), then a cross-reference of the SSNs should be indicated in the outpatient files as well as in the current automated system.

4.1.3. When patients from other Services are treated in Air Force facilities and require certain Service specific forms be completed and filed in the records, the documents will be filed in the record. The document will be placed in the appropriate section of the outpatient record based on the type of form. Use instructions in A3.4 to determine where to file other Service forms.

4.2. Creation and Maintenance of Health Records in Clinics:

4.2.1. Preparing Health Records for Patient Reporting for Treatment.

4.2.1.1. Clinic personnel will ensure the outpatient record is available prior to patient's appointment.

4.2.1.2. If a patient arrives at a clinic without his or her outpatient record, the appropriate request form is completed and presented to Outpatient Records. Outpatient Records will provide the record to clinic personnel. If the record is not available, the provider should make an entry on the form used to document care that the record was not available for review.

4.2.2. DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow Sheet** will be completed by the provider. Always file this form as the TOP FORM on the left side of the outpatient record. (See A3.5.1.-A3.5.3. for more information) NOTE: The AF Form 1480A has been superseded by the DD Form 2766. Some records may have the older AF form. There is no requirement to transfer the information from the AF form to the DD form. However a DD Form 2766 will be utilized for new patients and when a new form is needed.

4.2.3. Use SF 558, **Medical Record-Emergency Care and Treatment**, to document the diagnosis and care a patient receives in the Emergency Room.

4.2.4. Use SF 600 to document the diagnoses, treatments, notes, disposition of cases, and other information about the patient. Document any health education provided to the patient. Entries on the SF 600 will be signed and dated.

4.2.5. DD Form 2161, **Referral for Civilian Medical Care**, will be used for all consults, i.e. referrals within the MTF, in addition to outside referrals.

4.2.6. Request for Ancillary Services. Clinic personnel will ensure the appropriate ancillary request form is properly completed and shows all patient identification and other data required by directives. Develop local procedures between clinic and ancillary services to correct errors and avoid omissions.

4.2.7. Do not ask patients to complete forms except those forms used for physical examinations (e.g. periodic retirement, flying or employment physicals).

4.2.8. When Outpatient Records receive reports or documentation without adequate identification, they should send it back to the requester to complete. The requesting clinic completes the required entries and returns the report to the proper record section.

4.3. Disposition of Outpatient Records . Clinic personnel must keep outpatient record entries up-to-date and dispose of Outpatient Health Records as follows:

4.3.1. Outpatient Discharged from Treatment. All records are to be returned to the Outpatient Record Section. Do not give records to the patient to keep in their possession, or to hand carry to the outpatient record section. Throughout the day, records of patients who have completed their visit are gathered and returned to the outpatient records section. When a clinic closes for the day, records are returned to the appropriate files. Records are checked out and returned to the records section according to [attachment 6](#), section A6.1-A6.3.

4.3.2. Admission to Hospital. Send the outpatient record to the designated inpatient unit. Clinic personnel notify the Outpatient Records Section that the record is being sent to an inpatient unit and give the location. The records section updates the AF Form 250 or other appropriate charge out record to reflect this information.

4.3.3. Referral to Another Medical Facility or Civilian Consultant. The outpatient records section personnel are responsible for coordinating the information to be sent on scheduled referrals. If copies of appropriate portions of the record are not sufficient, the record is sealed in an envelope and receipts completed for the patient who hand carries it to the appointment. Staple a notice to the front of the record indicating the record should be returned promptly. Remove this sheet when the record is returned. Remind the patient to return the record immediately after the appointment. Update the AF Form 250 (or other charge out record) to show the current location of the record.

4.3.4. Transfer to Another Military Facility. Clinic personnel notify the outpatient records section when the record is being sent with the patient. Outpatient record personnel update the AF Form 250 (or other charge out record) to show the current location of the records.

4.3.5. Transfer of Mental Health Records. The outpatient records section will forward all lists of transferring military members provided by the Military Personnel Flight to the mental health clinic. The mental health clinic staff are required to check clinic files for records (active or inactive) of transferring patients and are to take appropriate action to ensure pertinent mental health information is made available to the gaining MTF. This may include such action as making a provider-to-provider call to the gaining MTF, or ensuring a treatment summary is annotated in the outpatient record. Action taken will be at the discretion of the mental health provider staff.

4.3.6. Deployment. See para 2.7 for management of outpatient records during deployment.

4.3.7. Inpatients Seen in Clinics. For inpatients seen in clinics, the clinic service returns medical documents that must be inserted into the inpatient record to the inpatient unit to provide a complete record of the inpatient visit.

4.3.8. Dead On Arrival (DOA) and Emergency Room Death (ERD). All DOA and ERD encounters will be reported in the Ambulatory Data System (ADS). Any documents created on these patients will be maintained in an Extended Ambulatory Record in a limited access area (i.e. file in a separate area of the inpatient/outpatient record file rooms). See paragraph 4.5 for instructions on maintenance of the EAR.

4.3.9. Variations in the disposition and maintenance of records in clinics are not authorized. The MTF Commander ensures that the health records are maintained as required by current Air Force directives.

4.4. Missing/Lost Records . An Air Force facility-wide search may be conducted upon request for any missing/lost records. The following information should be faxed to AFMOA/SGOI at DSN 240-5167 or Commercial (210) 536-5167:

Name

Sponsor's SSN

FMP (20, 30, 01, 02, etc.)

Pay Grade

Status (AD/AF, Dep Ret/USN, USNR, etc.)

Location and date where record was last seen

Point of contact should record be located (name and phone number)

4.5. Extended Ambulatory Records (EAR) . The EAR is a folder that contains information on treatment received during an Ambulatory Procedure Visit (APV), an observation stay, ERD, DOA, or other similar status. Each occasion of treatment will be maintained as a separate entity within the EAR similar to the way multiple admissions are maintained within a single inpatient record folder. The EAR will be maintained in a method similar to the inpatient record. The folder will be annotated with the patient's name, Family Member Prefix (FMP), and sponsor's Social Security Number (SSN). The EAR will be filed by the sponsor's SSN (same as the outpatient and inpatient records).

4.5.1. The EAR will be maintained in a limited access area to allow for risk management and quality improvement purposes. See paragraph 2.11.6 for instructions on retirement of Extended Ambulatory Records (EAR) to the NPRC in St. Louis, MO.

4.6. Ambulatory Procedure Visit (APV) Records.

4.6.1. Creation, Maintenance, and Disposition of APV Records.

4.6.1.1. Documentation on a patient seen during an APV will be filed in the EAR..

4.6.1.2. An APV record will be created for those cases when a patient is seen in the Emergency Room or specialty procedure room, an APV procedure is performed, and the patient is discharged within 23 hours and 59 minutes of the same day.

4.6.1.3. The MTF will maintain the record in a limited access area (preferably in the inpatient records section) for risk management and quality improvement purposes. The APV record will be filed by the sponsor's Social Security Number (same as the outpatient and inpatient records).

4.6.1.4. See [chapter 2](#) for disposition of the APV record.

4.6.2. Clinical Application of APV Records.

4.6.2.1. The medical record documentation for the APV must meet the standards of documentation similar to the short-term stay (abbreviated medical record) and be filed in a folder. The record documentation must comply with JCAHO standards. At a minimum, the record must include an abbreviated history and physical, progress notes, doctor's orders, patient's informed consent, operative report, tissue report (if any), anesthesia record, summary of care, to include discharge instructions, DD Form 2005 and an Advanced Directive. Copies of the summary, operative report, and any tissue reports are forwarded to the outpatient record.

4.6.2.2. It is recommended physicians sign an automated cover sheet or ambulatory encounter summary form for the APV records. All diagnoses and procedures are to be written in full, without symbols or abbreviations, in acceptable terminology.

4.6.2.3. The following forms are recommended for use in APV records:

SF 539, Medical Record - Abbreviated Medical Record

SF 509, Medical Record - Progress Notes

SF 516, Medical Record - Operative Report

OF 522, Medical Record - Request for Administration of Anesthesia and for Performance of Operations and other Procedures

OF 517, Medical Record - Clinical Record - Anesthesia

AF Form 560, Authorization and Treatment Statement, or automated cover sheet

AF Form 3066 (or 3066-1), Doctor's Orders

4.6.2.4. Until such time as Standard, Air Force or DD Forms are developed, each MTF may elect to develop local forms, as an alternative to the established forms listed in paragraph 4.6.2.3., to integrate documentation requirements into the comprehensive records. Any locally developed forms must be approved by the MTF's Medical Records Function before use in APV medical records. The MTF may utilize the ambulatory encounter summary form produced by the ADS as the cover sheet or the automated form available in the Composite Health Care System (CHCS) version 4.61.

4.6.3. Coding of APVs.

4.6.3.1. Diagnoses will be coded according to International Classification of Diseases (ICD)-9-CM diagnoses coding references or current coding classification system.

4.6.3.2. Procedures/operations will be coded according to Current Procedure Terminology (CPT) coding references.

4.6.3.3. The Ambulatory Encounter Summary forms or the automated APV form used for coding will be utilized in the APV record for auditing and quality assurance purposes.

4.6.4. Admission of APV Patients.

4.6.4.1. An APV patient that stays beyond the 24-hour time limit after surgery must be admitted as an inpatient. The admission date and time will not be backdated/timed to the point when the

patient's APV episode began. The date and time will be when the actual admission to the hospital occurs. Enter in the administrative section of the cover sheet **"Patient admitted from APU. Information on the APV procedure is maintained in the APV record."** The original APV documentation is not combined with the inpatient record but maintained separately. Copies of the ambulatory encounter summary form or automated cover sheet, the abbreviated history and physical, operative report, and any other pertinent documentation will be included in the inpatient record, as applicable.

4.6.4.2. The inpatient record will be coded with the reason that caused the subsequent admission.

4.7. Observation Records . Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required. Outpatient observation stays generally should not exceed 23 hours and 59 minutes. However, up to 48 hours may be authorized when medical necessity has been clearly demonstrated. Observation patients may be cared for in either dedicated observation units or in any designated bed space. Appropriate JCAHO standards will apply.

4.7.1. Documentation of Observation Records.

4.7.1.1. Documentation for an observation patient must meet the standards for a short-term stay (abbreviated medical record) and must comply with the current JCAHO documentation standards

4.7.1.2. Standard Forms (SF), or other forms as noted, are recommended for use in observation records. At a minimum, the documentation in the medical record will include:

DD Form 2005, Privacy Act Statement – Health Care Record

SF 558, Medical Record-Emergency Care and Treatment, as applicable

A plan of care to include medical orders, reasons for observation, diagnoses, and risks of complication

SF 509, Medical Record - Progress Notes, which reflect periodic patient assessment and interventions

All diagnostic reports (e.g., laboratory, radiology, or electrocardiogram) as applicable

AF Form 3066 (or 3066-1), Doctor's Orders

AF Form 3069, Medication Administration Record, as applicable

AF Form 3068, PRN Medication Administration Record, as applicable

AF Form 3067, Intravenous Record, as applicable

Patient education, release instructions, and plans for follow-up care

Advanced Directive

4.7.2. Coding of Observation Records.

4.7.2.1. Diagnoses will be coded according to ICD-9-CM diagnoses coding references or current coding classification system.

4.7.2.2. Procedures/operations will be coded according to the Current Procedure Terminology (CPT) coding references.

4.7.2.3. The Ambulatory Data System will be used to capture the coded information on observation patients, except when a patient is admitted.

4.7.3. Disposition of Observation Records.

4.7.3.1. All documentation related to an observation stay will be filed in the EAR. See paragraph 4.5.

4.7.3.2. The following documents will be forwarded to the outpatient treatment record:

4.7.3.2.1. Release note with summary of pertinent diagnostic findings

4.7.3.2.2. Status of patient upon release

4.7.3.2.3. Release instructions with plans for follow-up care

4.7.4. Admission of Observation Patients. When a patient is admitted from an observation status, the observation documentation is still filed in the EAR folder . Copies of pertinent documentation will be placed in the inpatient record.

4.8. Partial Hospitalization . Partial hospitalization is defined as a facility or unit that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility. Patients would spend a portion or majority of a day (less than 24-hour daily care) in a hospital setting and then return to their homes or places of residence in the evening. They would then return to the facility on the following day.

4.8.1. Partial hospitalizations are characterized by structured, daily supervised, outpatient activities over a prolonged period (usually 2-6 weeks) tailored to treat or rehabilitate individuals with generic-like illnesses, dependencies or psychological profiles. Partial hospitalization may be used for crisis stabilization, treatment of partially stabilized mental health disorders for adults and adolescents, chemical dependency treatment programs, or as a transition from an inpatient program when medically necessary.

4.8.2. All documentation for partial hospitalization must comply with the current JCAHO documentation standards. Standard Forms (SF), or other forms as noted, are recommended for use in the partial hospitalization records. At a minimum, the documentation in the medical record will include:

4.8.2.1. DD Form 2005, Privacy Act Statement – Health Care Record

4.8.2.2. SF 504, Medical Record - History, Parts I and II

4.8.2.3. SF 505, Medical Record - History, (Parts II and III)

4.8.2.4. SF 506, Clinical Record - Physical Examination

4.8.2.5. Nursing assessments and interventions

4.8.2.6. SF 509, Medical Record – Progress Notes, written daily, which reflects a brief summary of the therapeutic activity, observation of the patient's status and responses in the course of the therapeutic contact and the therapist's plans for any subsequent therapeutic contact.

4.8.2.7. AF Form 3066 (or 3066-1), Doctor's Orders

4.8.2.8. AF Form 3069, Medication Administration Record, as applicable.

4.8.2.9. Supporting documentation such as case management notes, treatment team notes, weekly progress summaries, and physician summaries including physician supervision, evaluation, and certification.

4.8.2.10. Patient education, release instructions, and plans for follow-up care.

4.8.3. All documentation related to the partial hospitalization stay will be filed as a package in the Mental Health or health record, as applicable. Illnesses related to mental health will be filed in the mental health record.

4.9. Records Transmittal and Receipt .

4.9.1. Records in a TRICARE Environment .

4.9.1.1. TRICARE records are property of the United States Government. Records shall be maintained by the TRICARE contractor until either the patient leaves their care or the contract is changed. At such time, the record shall be forwarded to the military treatment facility for retirement. Ensure that Memorandum of Understanding (MOU) and TRICARE contracts include a mechanism for obtaining documentation (i.e., summaries, operative reports, etc) to be incorporated into the individual's health record.

4.9.1.2. Copies of TRICARE records will be made for individuals seeking civilian care outside the TRICARE contracts. These copies may be hand-carried or mailed to the new civilian physician. For sensitive information (mental health, Acquired Immunodeficiency Syndrome (AIDS)), copies of the record will be placed in a sealed envelope stamped or otherwise marked "Sensitive Information, For Eyes Only of New Primary Care Manager." This envelope will be placed in another envelope and mailed to the Primary Care Manager. Inform the Primary Care Manager that sensitive records are being forwarded.

4.9.1.3. These records will be retired in accordance with AFMAN 37-139, Table 41-12. Records are maintained for two (2) years after the year of last treatment and then retired. Original health records are not released to any person or agency as described in para 2.2.1.

4.9.2. Geographically Separated Units. Active duty service members assigned to a geographically separated unit (GSU) residing more than 50 miles or approximately one hour of driving time from the nearest military medical facility adequate to provide the needed care are eligible for care at civilian and VA medical facilities. Refer to AFI 41-101 for the guidance and requirements for obtaining alternative medical and dental care. The Air Force MTF Commander or GSU Commander will ensure mechanisms are in place for documentation (i.e., summaries, operative reports, etc) to be incorporated into the individual's health record.

4.9.3. Mental Health Records . Mental health records are a separate category of records that contain detailed psychiatric notations of evaluations, consultations, tests, and treatment provided on an outpatient or inpatient status. Do not use AF Form 2100 or 2100A series for records kept in the mental health clinic. These records must be kept in properly secured files in the mental health clinic. See AFI 44-109, *Mental Health and Military Law* (para 3), for guidance on the Limited Privilege Suicide Prevention (LPSP) Program. Effective implementation of this program requires special handling of records generated while a patient is covered under that privilege to protect from unauthorized disclo-

sure and to meet the Government's burden during court-martial proceedings of proving that those records were not used inappropriately.

4.9.3.1. Place an AF Form 745 on the top right side in the mental health record of any individual involved with a sensitive duty.

4.9.3.2. On each outpatient visit the outpatient record is requested from the records section and an entry is made into the outpatient record in sufficient detail to enable health care providers in other clinics to provide effective continuing care to the patient. Changes in diagnosis, profile, therapy or medication require a specific note detailing such changes in the outpatient record. Personal information disclosed in therapy should not be entered into both the outpatient and mental health records.

4.9.3.2.1. Missed appointments should be documented.

4.9.3.2.2. An outpatient note is required when medication is prescribed, renewed, changed, or discontinued.

4.9.3.2.3. There should be an annual summary, if applicable, and a brief termination summary when the patient leaves treatment. This should be entered into both the outpatient and mental health records.

4.9.4. Mental health record documentation must be sufficiently detailed and organized to enable the practitioner responsible for the patient to provide continuing care to the patient, determine later what the patient's condition was at a specific time and review the diagnostic and therapeutic procedures performed and the patient's response to treatment.

4.9.5. Mental health clinics must review all active records every 6 months. Mental health and outpatient records of patients who have not had an appointment at the clinic for the past 3 months and who have not been formally terminated should be referred to the provider so that a termination summary can be entered in both the mental health and outpatient records.

4.10. Prenatal Records . Prenatal records may be maintained separately by the prenatal clinic and then must be incorporated into the inpatient record at the time of delivery.

4.10.1. If a patient is transferred or relocates before delivery, the prenatal record should be given to the patient to hand carry to the next MTF. If the patient does not expect to deliver in a MTF, copies of the prenatal record should be given to the patient and the original documents filed in the patient's outpatient record.

4.10.2. Prenatal records should be screened quarterly . When the expected date of delivery has passed or there is no indication that the patient is being followed, the prenatal record should be withdrawn from the prenatal file and forwarded to the outpatient records section for inclusion in the patient's outpatient record. If no outpatient record is available, prepare one.

4.11. Secondary Records. There may be specialty clinics that need to closely monitor their patient's response to therapy and choose to keep a copy of their clinic records available to them in the clinic. This is acceptable as long as there is ONE complete record in the MTF where total patient information is available for all care givers and the original of all records are placed in that central file.

Chapter 5

INPATIENT ADMINISTRATION

5.1. Admitting and Discharging Patients. Register, admit, and discharge patients using the current automated system. Establish local procedures to ensure the patient appropriately clears the facility. See attachment 4 for disposition instructions for specific categories of patients. Maintain a Register of Patients as a history of MTF admissions and discharges. Dispose of the register in accordance with AFMAN 37-139, Table 41-10, Rule 1.

5.2. Transferring Patients Between MTFs. Movements of patients between MTFs is outlined in AFJI 41-315, *Patient Regulating to and Within the Continental United States*. See attachment 5 for guidelines and attachment 11 for instructions on handling of the inpatient records.

5.3. Assuming Administrative Responsibility for Military Members Hospitalized in Nonmilitary Medical Facilities.

5.3.1. The MTF Commander at the nearest Air Force medical treatment facility, including clinics, ensures that appropriate tracking and follow-up processes are in place for any Air Force active duty or ARC member referred to or admitted in a nonmilitary medical treatment facility. If the patient is referred from the MTF, the referring provider ensures that the Admission and Disposition Office is notified. If a patient is directly admitted to the civilian facility, the Resource Management Office (RMO) is usually contacted by that facility. The RMO ensures that the Admission and Disposition Office is notified. The Admission and Disposition Office, in conjunction with the Chief, Medical Staff is responsible for tracking and follow-up. The decision on whether or not to transfer the patient to a MTF is based on economics and sound medical practice. For example, while it is probably prudent to transfer a “catastrophic” patient, an appendectomy patient should probably continue care at the non-military treatment facility.

5.3.1.1. Obtain full patient identification from the facility and promptly notify patient’s unit commander. If the patient is an ARC member and the unit commander is unknown, contact the appropriate ARC/SG (see Terms - Atch 1, Section C) for further guidance.

5.3.1.2. Obtain information on the patient’s diagnoses, any procedures performed and prognosis. The civilian medical treatment facility is reimbursed for the patient’s care based on the Diagnosis Related Group (DRG). A complete summary of the patient’s treatment while under the care of the civilian health care provider is required after the patient has been discharged. A Standard Inpatient Data Record (SIDR) will be transmitted. However, the complete summary is not required before the SIDR can be transmitted. Information regarding the diagnoses and any procedures can be obtained from the Resource Management Office or the managed care contractor.

5.3.1.3. The Military Medical Support Office (MMSO), once in operation, will be responsible for tracking Geographically Separated Unit (GSU) personnel receiving medical care in non-federal medical facilities. Follow the same procedures outlined in paragraphs 5.3.1.1 and 5.3.1.2.

5.3.1.4. See AFI 36-3002, *Casualty Services*, for seriously ill or death cases.

5.3.1.5. Prepare AF Form 438, **Medical Care Third Party Liability Notification**, if applicable. See AFI 41-120, *Medical Resource Management Operations*.

5.3.1.6. Prepare AF Form 348, **Line of Duty Determination**, if applicable. See AFI 36-2910.

5.3.1.7. Complete AF Form 560, **Authorization and Treatment Statement**. Enter the data into the current automated system. Clinics without automation will produce a manual AF Form 560. If the narrative summary is not obtained in a timely fashion, complete the coding using diagnostic and procedure information received by the RMO with the bill. See attachment 9 for further guidance. **NOTE:** Does not apply when the member elects care at his/her own expense unless the member is hospitalized for purposes of being an approved organ donor in accordance with AFI 44-102.

5.3.2. For active duty Air Force or ARC members with emergency admissions in a uniformed services treatment facility (USTF) or VA hospital or for transfers to same from other Service medical treatment facilities, the commander of the nearest Air Force medical treatment facility assumes medical administrative responsibility and arranges transfer to a military hospital in accordance with paragraph 5.3.1. If the member was referred to the USTF or VA hospital by, the referral MTF maintains the medical administrative responsibility.

5.3.3. ARC and other geographically separated units will notify, as soon as possible, the nearest MTF when one of their members is hospitalized in a civilian medical facility. For ARC members, the medical reason for hospitalization must have been determined to be "in line of duty" by the appropriate ARC authority IAW AFI 36-2910/AFRC supplement.

5.3.4. Upon notification that an Army active duty member is hospitalized in a nearby nonmilitary medical facility, the commander of the nearest Air Force medical treatment facility obtains the patient's identifying data and notifies the nearest Army medical treatment facility, as appropriate, and the individual's unit commander. Notification of Navy active duty members hospitalized in a nearby nonmilitary medical facility is made to Medical/Dental Affairs, Great Lakes, IL, 800-876-1131. The commander takes prompt action to keep the designated parent service representative informed of the patient's status when requested to assume administrative responsibility of a patient from another Service branch.

5.3.5. Coast Guard, Public Health Service or foreign military personnel admitted to nonmilitary facilities are not admitted as "Absent Sick", not entered into the current automated system, and not reported to higher headquarters.

5.3.6. Notify the base ground safety officer in accident cases.

5.4. Assuming Administrative Responsibility for Active Duty Air Force Members Hospitalized in Army or Navy Medical Treatment Facilities. The nearest Air Force medical treatment facility commander assumes administrative responsibility and ensures that the following procedures are carried out for Air Force personnel hospitalized in Army or Navy medical treatment facility:

5.4.1. Coordinates with the Army or Navy medical treatment facility on behalf of Air Force patients.

5.4.2. Keeps rosters and pertinent data on hospitalized Air Force patients and notifies the member's organization.

5.4.3. Prepares AF Form 348, when applicable, in accordance with AFI 36-2910.

5.4.4. See AFI 36-3002 for seriously ill or death cases.

5.4.5. Complies with AFI 41-101, and AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)*.

5.4.6. Notifies the base ground safety officer in accident cases.

5.4.7. Reassigns patients to the patient squadron of the responsible Air Force medical treatment facility in accordance with AFI 36-2110, *Assignments*, if hospitalization of 90 days or more is expected.

5.4.8. Prepares AF Form 438 when applicable.

5.5. Reporting Patients in Casualty Status. A patient placed in a casualty status is reported in accordance with AFI 36-3002. Categories of patients requiring special casualty reports are VSI, SI or III (patient suffering an incapacitating illness or injury). See attachment 7.

5.6. Reporting Infants Born Outside the MTF.

5.6.1. Infants born outside the MTF (i.e., at home or enroute to the hospital) are admitted as “Live-born” when admitted with the mother for post-partum care. Admission must occur within a reasonable time period after birth. Verify that delivery in the military hospital was intended and process the same as for infants born in the hospital.

5.6.2. If the admission and birth occurred in a civilian hospital and the mother and baby are later transferred to the MTF, admit the infant as a direct admission (not a “Liveborn”).

5.6.3. When a newborn infant is transferred to another MTF, the receiving MTF admits the infant as a direct admission.

5.7. Admitting Generals/Flag Officers and Dependents, Colonels, and Prominent Persons (HAF-SGX (D) 9909).

5.7.1. Definition of Terms:

5.7.1.1. General officers: Includes all General/Flag Officers (O-7 and above) to include Guard, Reserve and foreign officers (includes civilian equivalents, see para 5.7.1.3.). Dependents of AD and retired are included in the reporting process.

5.7.1.2. Colonels: Includes Air Force active duty only that are seriously ill, expected to be hospitalized greater than 10 days, given a profile change because of any medical or surgical condition affecting the members assignability. All colonels that are part of the Air Force Medical Service (AFMS) will be reported upon admission (see para 5.7.1.4.). Do not report on dependents.

5.7.1.3. Prominent Persons: Includes Senior Executive Staff (SES), political officials, high ranking public officials, and medical executive staff personnel (includes enlisted members of medical executive staff). Do not report on dependents.

5.7.1.4. Admission and Extended Ambulatory Care: Admission to an MTF or other than AF facility for which the MTF assumes administrative responsibility. This includes in-patient units and other extended care services, i.e. ambulatory patient visits, observation and partial hospitalization.

5.7.1.5. Sanitized information: Patient’s name, rank, age, unit of assignment (if AD), and admission/treatment date to include dependents of AD and retired General and Flag Officers.

5.7.1.6. Comprehensive Medical Information: Patient's name, rank, age, status (i.e. AD, ARC, retired, dependent) unit of assignment (if AD), date of admission or date of treatment, diagnosis, current medical status and projected length of stay. This includes dependents of AD and retired GO/FOs.

5.7.1.7. Information Conduits: Command Posts or Operations Centers at the base or MAJCOM level. HQ AF/SGXO, Air Force Medical Operations Center (MOC) can be reached at DSN 227-9075 or 8611 or commercial (703) 697-9075 or 8611. Air Force Operations Center can be reached at DSN 227-6103 commercial (703) 697-6103 and ask for the medical person on call.

5.7.2. Local Notification Procedures when a General/Flag Officer, Colonel or Prominent Persons is Admitted.

5.7.2.1. The admission and dispositions section (or locally appointed designee) will provide sanitized information telephonically to the Medical Treatment Facility (MTF) Commander.

5.7.2.2. Notifications will be made as soon as possible and preferably no later than 12 hours after admission.

5.7.2.3. The MTF Commander will notify the Installation Commander via appropriate information conduits.

5.7.3. HQ AF Notification Procedure when a General/Flag Officer, Colonel or Prominent Persons is Admitted.

5.7.3.1. Comprehensive medical information will be provided telephonically to HQ AF/SGXO-MOC minimally by 0600 EST of every duty day.

5.7.3.2. Leave only sanitized information on the MOCs password protected phone lines. Include call back phone numbers so the MOC can get comprehensive medical information as needed.

5.7.3.2.1. In unusual circumstances, if the MTF Commander determines AF/SG should be notified during non-duty hours, call the Air Force Operations Center and ask for the medical person on call.

5.7.3.3. Comprehensive medical information is required minimally by 0600 EST of every duty day.

5.7.3.4. Updates will be provided every duty day by 0600 EST from an MTF individual familiar with the patient and his/her current medical status (i.e. Nursing Supervisor, or Nurse responsible for the patient).

5.7.3.5. Medical Centers will call by 0600 EST every duty day to include negative replies.

5.7.4. HQ USAF/Medical Operations Center Responsibilities:

5.7.4.1. The MOC will create 2 slides from the information.

5.7.4.1.1. The first slide includes sanitized information only.

5.7.4.1.1.1. The sanitized information slide is forwarded in password protected mode only to the Chief, Air Force General Matters Office (GOMO) via his/her Pentagon e-mail address.

5.7.4.1.1.2. HQ USAF/SG/SG2 or his/her representative will receive the slide via live brief or in password protected electronic format. HQ USAF/SG/SG2 or his/her representative will provide the information to CSAF.

5.7.4.1.1.3. If the slide has an ADAF 0-6 that is seriously ill, expected to be hospitalized greater than 10 days, given a profile change because of any medical or surgical condition affecting the member's assignability, the information will be provided to the Air Force Colonel Matters Office Support Division.

5.7.4.1.2. The second slide will include comprehensive medical information and be provided only to HQ USAF/SG/SG2 or his/her representative, via live brief. It will not be sent in electronic format.

5.7.4.2. The MOC will notify the MAJCOM SG (includes ANG/SG, and AFRC SG).

5.8. Reporting Aircraft Accident Admissions . For specific instructions see AFI 91-204, *Safety Investigations and Reports*, paragraph 7.4. The command surgeon of the MAJCOM owning the aircraft involved notifies AFMOA/SGOA, DSN 297-4200, of admission resulting from any aircraft accidents (active Air Force, Reserve, or Air National Guard).

5.8.1. Provide the diagnosis, estimated period of hospitalization, and probable disposition of personnel.

5.8.2. During regular duty hours, notify AFMOA/SGOA by telephone. After duty hours, notify HQ USAF/SG Duty Officer through the Air Force Operations Center, DSN 297-1111. The appropriate MAJCOM also notifies HQ AFMOA of the initial clinic visit, diagnosis, estimated period of treatment, and the probable disposition of personnel who are examined or received treatment for injuries incurred as a result of an aircraft accident.

5.9. Managing Military Patients Expected To Be Hospitalized Over 90 Days .

5.9.1. Notify the patient's servicing MTF and military personal flight (MPF) when a patient will be reassigned or hospitalized over 90 days.

5.9.2. The staff at the admitting MTF must advise the local traffic management office (TMO) and MPF of the person's hospitalization and the expected duration when a patient is hospitalized while traveling to a Continental United States (CONUS) port for PCS overseas.

5.10. Notifying the VA of Admission of a Veteran Who At Any Time Filed a Claim. Complete two copies of VA Form 21-8359, **Notice to VA of Admission to Uniformed Services Hospital**, for a veteran previously admitted as an inpatient. Send a copy of the form to the VA regional office in the state where the veteran resides and file the other copy in the inpatient record.

5.11. Assigning or Attaching Military Patients . Refer to AFI 36-2110 for assigning or attaching military patients. For cases involving patients undergoing Medical Boards, also see AFI 48-123, *Medical Evaluation Boards and Continued Military Service*.

5.12. Readmission of Patients.

5.12.1. Reactivate the record of hospitalization if the patient is readmitted before 2400 hours (in other words midnight) on the same day as discharged for the same reason as the first admission. The attend-

ing provider annotates the reason for readmission and the hospitalization is considered as one continuous period.

5.12.2. If the patient is readmitted after 2400 hours, or the reason for readmission is different from that of the previous admission, create a new record.

5.13. Canceling Admissions. See attachment 11 for guidance.

5.14. Rank for OSI Agents. When entering the rank for OSI agents into the current automated system, enter the rank for Airman Basic (E-1) regardless of the agent's actual rank. The purpose is to provide a protection mechanism for the agent.

Chapter 6

MANAGING BIOMETRIC DATA

6.1. The biometric data process. Biometric data is information about patient encounters with the health care system. Components include basic identifying information about the facility and the medical staff involved in treatment of the patient, demographic information about the patient, and information identifying services provided during the encounter (to include diagnostic and therapeutic data). Biometric data are created in two source data collection systems and collected in three primary data records as follows:

6.1.1. Composite Health Care System (CHCS) is the source data collection system for inpatient biometrics and facility workload data.

6.1.1.1. Standard Inpatient Data Record (SIDR) is the biometric data record for all inpatient treatments including active duty members hospitalized in non-military medical treatment facilities. The SIDR record is created using the Patient Administration (PAD) module of CHCS. Detailed instructions for SIDR processing are contained in DODI 6040.39, *DOD Disease and Procedure Classification ICD-9-CM Coding Guidelines*, and the CHCS User's Manual. The SIDR file will be transmitted once a month to AFMOA/SGOI. Creation and transmission of the file for a given month will be completed by the 5th working day of the following month.

6.1.1.2. World-wide Workload Report (WWR) is the biometric data record for all MTF workload. The WWR is automatically created as a byproduct of both the PAD and patient appointment scheduling (or managed care scheduling) modules of CHCS. Detailed instructions for WWR processing are contained in the WWR User's Manual and the CHCS User's Manual. The definition of a reportable visit is in attachment 12.

6.1.2. Ambulatory Data System (ADS) is the source data collection system for ambulatory care biometrics.

6.1.2.1. Standard Ambulatory Data Record (SADR) is the biometric data record for all patient ambulatory treatments including Emergency Room Deaths (ERD), Dead on Arrival (DOA) cases, Ambulatory Procedure Visits (APV), observation cases, and partial hospitalizations.

6.1.2.2. Detailed guidance on operating the ADS, coding of ambulatory encounters, and submitting SADR files is contained in *The ADS Guidelines for Diagnoses and Procedure Coding*, the ADS Fundamentals and Insights, and ADS Implementation Guide.

6.2. Vital nature of biometric data. The information contained in and derived from biometric data records forms the basic building blocks for a large number of critically important Military Health System (MHS) functions. Clinically, data is used in provider profiling, provider credentialing, certification of Graduate Medical Education (GME) programs, utilization management, and clinical pathways, among others. From a facility quality assurance perspective this data is used to compute National Committee for Quality Assurance (NCQA) Health Plan Employers Data and Information Set (HEDIS) scores, document compliance with JCAHO standards, and calculate AF and MHS metrics. Financially, the information is used in managing TRICARE contract bid-price adjustments, third party collections, and capitation budgeting. Operationally, the data is a necessary component of military force protection efforts as it documents key components of the clinical medical readiness of deployed forces including immunization

status, pre and post deployment treatments and conditions, and medical services provided to deployed personnel.

6.3. Biometric information quality management. Given the critical nature of the data, commanders at all levels must take positive management actions to ensure the quality of the biometric data produced or managed by their organization. There must be a Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT) or a Certified Coding Specialist to oversee and ensure the quality of the coding (i.e., diagnostic and procedure coding) and the documentation to support the codes.

6.3.1. Data quality management program. It is essential that Commanders establish a formal process by which to monitor, measure, assess, and improve facility biometric data quality.

6.3.2. Principles of data quality management. Simply put, information (data) is a secondary output of the health care system. As with many other system outputs it can best be understood, measured, and managed using the principles of total quality management (TQM). AF Handbooks 90-502, *The Quality Approach*, and 90-503, *Process Improvement Guide*, are excellent basic references for developing such programs.

6.3.3. Commander's data quality program. The essential components of a commander's data quality management program include data quality standards, data quality metrics, data verification/audit, and a formal program emphasizing positive assignment of responsibility, results-based performance evaluation, and regular executive reviews.

6.3.3.1. Data quality standards. In order to manage quality, it is important to first understand and quantify what is being managed. The four "key quality characteristics" (KQC) for data are timeliness, completeness, accuracy, and comparability. Quantifiable standards for each KQC are determined based upon the information user's business driven requirements.

6.3.3.1.1. Timeliness of information reflects the "cycle time" from creation of the information (i.e., entry into the source data collection system) until a completed data record is delivered to the user. Timeliness is usually expressed in terms of days.

6.3.3.1.2. Completeness indicates the percent of qualifying data records that are "finalized" and in the data base at the time of measurement. Completeness is expressed as a percentage and is closely related to timeliness.

6.3.3.1.3. Accuracy indicates the degree to which the electronic data record reflects the actual event being recorded. For biometric information this normally requires a physical "audit" comparing the data record to the written information contained in the patient record (e.g., ICD and CPT codes assigned to the patient encounter should accurately reflect the actual services documented by the provider in the patient record). Accuracy is normally expressed as a percentage.

6.3.3.1.4. Comparability indicates that degree to which an organization's data compares to that produced by similar external organizations. This is an important feature if organizational performance is being "benchmarked" against "best in industry" standards. It is, in essence, the "apples to apples" measure.

6.3.3.2. Data quality metrics. At a minimum, commanders should monitor their performance against the metrics established in AFRD 41-2, *Medical Support*. Metrics currently exist for the

timeliness and completeness of SIDR submissions (i.e., percent of records completed within a specified period of time). Additional AFMS or MHS metrics may be established in future revisions of the AFPD or by issuance of AF/SG policy memoranda. Commanders are also strongly encouraged to establish internal metrics to monitor data quality.

6.3.3.3. Data verification/audit. System oversight is key to ensuring there is no weakness in source data systems. Metrics alone will not give the entire picture. Is the data entered into the system correctly? Attachment 13 describes minimum requirements of a verification/audit program.

6.3.3.4. Explicit assignment of responsibility. While data quality is the end product of a cross-functional (e.g., PAD, Resource Management, Information Systems, Clinical) team effort, it is essential that the team have a captain. The AF/SG adheres to the concept of information product line management of biometric data. Responsibility for overseeing the facility, Major Command, and Air Force biometric data quality program must be positively assigned to a designated individual or individuals, referred to as the product line manager (PLM). AFMOA/SGOI is the Air Force PLM for all biometric data. Within SGOI, PLMs are designated for ambulatory data (SADR), inpatient data (SIDR) and workload data (WWR). Past experience at the facility level indicates that best results are obtained when responsibility for output is placed with those producing the data input. For biometric data, it is suggested that a clinical leader within the operations squadron be the designated PLM. Experience also indicates that a cross-functional team approach consisting of clinical, systems, administration, and functional experts is most effective in implementing the system and process changes needed to improve performance.

6.3.3.5. Results-based performance evaluation. Designated responsible individuals should be evaluated, at least in part, on their success in meeting quantified data quality metrics. Civilian performance standards and military performance reports are excellent vehicles.

6.3.3.6. Ongoing executive management attention is a vital component of a data quality management program. Regularly scheduled presentation of quality indicators to executive management teams is one highly effective means to ensure visibility.

6.4. Forms Prescribed.

AF Form 230, Request for Patient Transfer

AF Form 250, Health Record Charge Out Request

AF Form 560, Authorization and Treatment Statement

AF Form 565, Record of Inpatient Treatment

AF Form 569, Patient's Absence Record

AF Form 570, Notification of Patient's Medical Status

AF Form 577, Patient's Clearance Record

AF Form 665, Health Record Year Grid

AF Form 745, Sensitive Duties Program Record Identifier

AF Form 788A-788J, Inpatient Record

AF Form 1403, Roster of Seriously Ill/Very Seriously Ill

AF Form 1480, Summary of Care

AF Form 1942, Clinic Index

AF Form 1976, Hematology

AF Form 2100A, Health Record - Outpatient

AF Form 2110A, Health Record - Outpatient

AF Form 2120A, Health Record - Outpatient

AF Form 2130A, Health Record - Outpatient

AF Form 2140A, Health Record - Outpatient

AF Form 2150A, Health Record - Outpatient

AF Form 2160A, Health Record - Outpatient

AF Form 2170A, Health Record - Outpatient

AF Form 2180A, Health Record - Outpatient

AF Form 2190A, Health Record - Outpatient

AF Form 3066, Doctor's Orders (multiple copy format)

AF Form 3066-1, Doctor's Orders (cut sheet format)

AF Form 3068, PRN Medication Administration Record

AF Form 3069, Medication Administration Record

PAUL K. CARLTON, Jr., Lieutenant General, USAF, MC, SFS
Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Public Health Service Act (42 CFR Part 2; 42 U.S.C. 290dd-2)

5 U.S.C. 552, Freedom of Information Act

5 U.S.C. 552a, The Privacy Act

Title 10, United States Code, Section 8013

41 Code of Federal Regulations, Part 2

DoDR 5400.7/AF Supplement, Freedom of Information Act Program

AFI 31-205, Corrections Program

AFI 33-119, Electronic Mail (E-Mail) Management and Use

AFI 33-332, Air Force Privacy Act Program

AFI 34-501, Mortuary Affairs Program

AFI 36-2101, Classifying Military Personnel (Officers and Airmen)

AFI 36-2104, Nuclear Weapons Personnel Reliability Program

AFI 36-2110, Assignments

AFI 36-2608, Military Personnel Records Systems

AFI 36-2910, Line of Duty (Misconduct) Determinations

AFI 36-3002, Casualty Services

AFI 36-3003, Military Leave Program

AFI 36-3026(1), Identification Cards for Members of the Uniformed Services, Their Family Members, and Other Eligible Personnel

AFI 36-3208, Administrative Separation of Airman

AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation

AFI 37-124, The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections

AFI 37-138, Records Disposition – Procedures and Responsibilities

AFI 37-160, Vol 8, The Air Force Publications and Forms Management Program – Developing and Processing Forms

AFI 41-101, Obtaining Alternative Medical and Dental Care

AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)

AFI 44-102, Community Health Management

AFI 44-109, *Mental Health and Military Law*

AFI 48-123, *Medical Evaluation Boards and Continued Military Service*

AFI 44-119, *Medical Clinical Performance Improvement*

AFI 47-101, *Managing Air Force Dental Services*

AFI 48-123, *Medical Examination and Standards*

AFI 51-301, *Civil Litigation*

AFI 51-604, *Appointment To and Assumption of Command*

AFI 65-103, *Temporary Duty Orders*

AFI 91-204, *Safety Investigations and Reports*

AFPD 41-2, *Medical Support*

AFH 41-114, *Military Health Services System (MHSS) Matrix*

AFMAN 37-139, *Records Disposition Schedule*

AFJI 41-315, *Patient Regulating To and Within the Continental United States*

Abbreviations and Acronyms

ADS—Ambulatory Data System

AFMAN—Air Force Manual

AFSC—Air Force Specialty Code

AIDS—Acquired Immunodeficiency Syndrome

AMC—Annual Medical Certificate

AOD—Administrative Officer of the Day

APV—Ambulatory Procedure Visit

ARC—Air Reserve Component

ASF—Aeromedical Staging Flight

ATH—Air Transportable Hospital

CAL—Casualty Affairs Liaison

CFR—Code of Federal Regulations

CHCS—Composite Health Care System

CONUS—Continental United States

CPO—Civilian Personnel Office

CPT—Current Procedural Terminology

CRO—Carded for Record Only

DBMS—Director of Base Medical Services

DEERS—Defense Enrollment Eligibility System

DOA—Dead on Arrival

DVA—Department of Veterans Affairs

EAR—Extended Ambulatory Record

EMF—Employee Medical Folder

ER—Emergency Room

ERD—Emergency Room Death

ETS—Expiration of Term of Service

FMP—Family Member Prefix

FOIA—Freedom of Information Act

GSU—Geographically Separated Unit

HHS—Department of Health and Human Services

HIPAA—Health Insurance Portability and Accountability Act

HIV—Human Immunodeficiency Virus

IG—Inspector General

III—Incapacitating Illness or Injury

ICD-9-CM—International Classification of Diseases – Clinical Modification

ICMR—Interagency Committee on Medical Records

IMA—Individual Mobilization Augmentee

ITO—Invitation Travel Order

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

LOD—Line of Duty

MAJCOM—Major Command

MEB—Medical Evaluation Board

MHS—Military Health System

MOOTW—Military Operations Other Than War

MPF—Military Personnel Flight

MPI—Master Patient Index

MSA—Medical Service Account

MTF—Military Treatment Facility

NOK—Next of Kin

NSI—Not Seriously Injured

NPRC—National Personnel Records Center
OF—Optional Form
OSI—Office of Special Investigation
PA—Privacy Act
PCS—Permanent Change of Station
PEB—Physical Evaluation Board
PEBLO—Physical Evaluation Board Liaison Officer
PL—Public Law
PLM—Product Line Manager
POMR—Problem Oriented Medical Record
PRP—Personnel Reliability Program
PS—Presidential Support
PSDA—Patient Self Determination Act
RD—Reinforcement Designees
RHIA—Registered Health Information Administrator
RHIT—Registered Health Information Technician
SADR—Standard Ambulatory Data Record
SAF—Secretary of the Air Force
SDO—Staff Duty Officer
SF—Standard Form
SI—Seriously Ill
SIDR—Standard Inpatient Data Record
SJA—Staff Judge Advocate
SO—Subsisting Out
SSN—Social Security Number
TDRL—Temporary Disability Retirement List
TMO—Traffic Management Office
USINS—U.S. Immigration and Naturalization Service
USTF—Uniformed Services Treatment Facility
VSI—Very Seriously Ill
VA—Veterans Affairs
VARO—Veterans Administration Regional Office

WWL—Worldwide Locator

WWR—Worldwide Workload Report

Terms

Appropriate ARC/SG—HQ AFRC/SGP for unit assigned reservists, DSN 497-0603. HQ ARPC/SGS for Individual Mobilization Augmentees (IMA), DSN 926-7237. ANGRC/SGP for guardsmen, DSN 278-8550.

Attending Physician—The physician who has the primary responsibility for the medical diagnosis and treatment of the patient.

Air Reserve Component (ARC)—)Members and units of the Air Force Reserve and Air National Guard.

Consent to Release Medical Information—Authorization for the patient or the individual's legal representative to release information. **Note:** A routine, general authorization for the release of information is not adequate for disclosing information from records containing drug/alcohol abuse, treatment, or rehabilitation information.

Convalescent Leave—An authorized leave status granted to active duty uniformed service members while under medical or dental care that is a part of the care and treatment prescribed for a member's recuperation or convalescence.

Domiciliary Care—Inpatient institutional care given to a beneficiary where the patient's family members will not provide the care, not because it is medically necessary, but because care in a home setting is either not available or is unsuitable,.

Highly Sensitive Records—Health records, correspondence (including working papers), and laboratory results, which may have an adverse effect on the morale or character of the patient or other person(s). Highly sensitive records include but are not limited to alleged or confirmed information relating to the treatment of patients for sexual assault, criminal actions (including child or spouse abuse), psychiatric or social conditions, or venereal disease. Claims against the government (including malpractice) are also considered highly sensitive.

Inpatient Records Library—The library provides resources for clinical reference and research, supports specialty training and post graduate programs, provides the means for accomplishing analysis and establishing trends, etc.

Power of Attorney—A legal document authorizing an individual to act as the attorney or agent of the grantor. General rules and individual state laws specify when a power of attorney is required. Refer any questions pertaining to power or attorneys to the legal office.

Sensitive Medical Information—Information which may affect the patient's morale, character, medical progress, or mental health. This includes the specific location or description of illness or injury, which may prove embarrassing to the patient or reflect poor taste. If the patient consents, information relating to the description of disease or injury and general factual circumstances may be released. **NOTE:** To protect the sensitive nature of the information, records or documents will be sent directly through medical channels when considered advisable by the health care provider or MTF Commander.

Subsisting Out—The non-leave status of an inpatient who is no longer assigned a bed. Inpatients authorized to subsist out are not medically able to return to duty, but their continuing treatment does not

require a bed assignment; subsisting out days are not counted as occupied bed days, but as sick days.

Written Consent—Written authorization from the patient or authorized representative allowing release of information.

Attachment 2**CORRECTING HEALTH RECORDS**

A2.1. Correcting Erroneous Data . Take the following action when an error is identified near in time to the erroneous entry date and the responsible practitioner has current memory of the circumstances.

A2.1.1. Line through the incorrect data with one straight line. Do not erase, scratch out or otherwise destroy the original data. Amendment of erroneous data should be done by the originating practitioner. If that is impractical, enter a brief explanation of why the originating provider did not make the correction. Enter the correct data next to the lined through data if space permits. Only providers privileged to document patient care will make corrections. The date for all entries or corrections must be the actual date of the notation.

A2.1.2. If there is not enough room on the record to enter the correction, draw one straight line through the entry, initial, date and make a referral note. Then enter the correction chronologically as indicated on the referral note. If the correction is not self-explanatory, also enter the reason for the correction. Sign and date the new entry. If other practitioners are associated with the patient's care and have a need-to-know concerning the change, inform them of the correction.

A2.2. Correcting Data for Special Cases . Take the following action if an error is identified after a claim or lawsuit has been filed or after a substantial time lapse:

A2.2.1. Do not automatically amend the record in the manner outlined in A2.1. when the adequacy of care has been challenged by the patient. Any amendment of the actual record is likely to create an appearance and allegation of record tampering. Consult the SJA or area medical law consultant for guidance.

A2.2.2. The practitioner with personal knowledge of the erroneous data, prepares a separate statement of fact with the assistance of the SJA. The statement becomes a part of the claim or litigation file. Notify all practitioners involved with the patient's care if the erroneous data could affect the patient's future care.

A2.3. Appealing Erroneous Information . Active duty members who believe their medical records contain erroneous information may apply to the Air Force Board of Correction of Military Records, SAF/MIBR, 550 C Street West, Suite 40, Randolph AFB TX 78150-4742. The medical treatment facility will take no action until contacted by the board representatives.

Attachment 3

PREPARING AND FILING HEALTH RECORD FOLDERS

A3.1. Outpatient Records.

A3.1.1. Number folders according to the social security number (SSN) as follows:

If the patient is:	Use SSN of:
Active Duty/ARC	Member
Family Member	Sponsor
Family Member <u>and</u> ARC Member	Sponsor (see note)
Civilian Employee	Employee
Retired Military	Retired military
Civilian Emergency	Patient

NOTE: Only one medical record will be established and maintained by the MTF. Cross reference the individual's SSAN on the front of the medical record as indicated in para A3.2.1.9. The only exception will be if the family member's reserve unit of assignment is not a tenant at the same base where the sponsor is assigned. In these cases, separate medical records (military and family member) will be maintained. The military medical record will be maintained as described in para A3.3.3.

A3.1.2. A pseudo-SSN is created for beneficiaries without a SSN. This process occurs in the Defense Eligibility and Enrollment Reporting System (DEERS) when the personnel technician issues an ID card or enrolls the beneficiary. Either a Foreign Identification Number (FIN) or a Temporary Identification Number (TIN) is generated. An Interim change to AFI 36-3026(1), Identification Cards for Members of the Uniformed Services, Their Family Members, and Other Eligible Personnel includes this information.

A3.1.2.1. When issuing an ID card, the DEERS gives the personnel technician a choice to enter an SSN, FIN or TIN. When FIN is selected, DEERS automatically assigns a 900-00-000F. This number is assigned to categories of eligible NATO and non-NATO foreign military members, their family members, and for foreign nationals employed in positions overseas that result in DoD benefits and entitlements.

A3.1.2.2. A TIN is assigned and automatically generated by the DEERS (800-00-000D) for categories of beneficiaries who are awaiting an SSN (such as newborns) or for those who do not have a SSN. The TIN is used as a method to record the beneficiary as a potential patient on DEERS while awaiting an SSN. Foreign nationals who are the spouse of a U.S. citizen will be issued a TIN.

A3.1.3. Select the appropriate AF Form 2100A series according to the last two digits of the applicable SSN. **Note:** File outpatient civilian emergency records by SSN in a manila folder. Maintain folders separately from the main file if desired. However, they must be interfiled by SSN with the rest of the records when retired to NPRC.

A3.1.4. Maintain civilian employee medical records in manila folders or SF 66D, **Employee Medical Folder**. Place the record in SF 66D when the employee transfers to another Federal agency or is separated from Federal Service. Send the record to the civilian personnel office (CPO). Civilian employees [including Air Reserve Technicians (ARTS)] who are also members of an ARC will have one medical record maintained as indicated in para A3.3.3. The only exception will be if the individual is

not employed as a civilian at the same base where his/her ARC unit is assigned. In these cases, a civilian medical record will be maintained as described in the beginning of this paragraph.

A3.2. Preparing File Folders:

A3.2.1. AF Forms 2100A, 2110A, 2120A, 2130A, 2140A, 2150A, 2160A, 2170A, 2180A and 2190A, **Health Record – Outpatient.**

A3.2.1.1. Select an AF Form in the 2100A series according to the last two digits of the applicable SSN:

Last two digits of SSN:	Use AF Form:
00-09	2100
10-19	2110
20-29	2120
30-39	2130
40-49	2140
50-59	2150
60-69	2160
70-79	2170
80-89	2180
90-99	2190

A3.2.1.2. Print the first name, middle initial, and last name of the patient in the space provided with a black pen, felt-tip marker, or embossed card. Address labels prepared by the Personnel Data System may be used to provide names of military personnel. DO NOT use pencil for any entry. Always place information in the upper right-hand corner of the cover in the patient ID area.

A3.2.1.3. Enter the sponsor's SSN in the preprinted blocks in the upper right-hand corner of the record.

A3.2.1.3.1. Enter the family member prefix in the two circles next to the SSN. Assign numbers in birth date order for family member children.

A3.2.1.3.2. The family member prefix does not change as long as it remains with the same sponsor and SSN.

A3.2.1.3.3. When a military member marries a person with children, assign family member prefix numbers in sequence following the last family member prefix already assigned to children of the sponsor (if any). Assign the oldest the next number in numerical sequence, etc.

A3.2.1.3.4. Assign the family member prefix "30" to the first spouse authorized care in accordance with AFI 41-115. The former spouse also retains the SSN of the sponsor. Assign subsequent spouses who are also authorized care FMP 31-39.

A3.2.1.4. Do not make any entries in the small preprinted, numbered blocks, the "R" and "S" blocks at the top of the folder, or the "R" block on the side of the folder (these are for Army use only).

A3.2.1.5. Blot out the ½-inch square block, along the right edge of the back leaf of the folder, containing the same digit as the last digit of the SSN, with a black ink pen, felt-tip marker, or black tape. **NOTE:** Use red instead of black to identify the folder of an individual assigned to the Sensitive Duty Program. Green tape may be used for personnel on mobility. Cover the red or green

tape with black tape when the member is removed from either program. Stamp “PRP” in two-inch block letters on the left hand side of the front of the folder for persons in the Personnel Reliability Program.

A3.2.1.6. Records maintained in aerospace medicine services include but are not limited to missile launch members, air traffic control personnel, physiological training personnel, parachute duty personnel, and weapons control personnel.

A3.2.1.6.1. Mark these folders with a strip of black tape on the side of the folder, extending from immediately below block “9” to the bottom of the folder. If file cabinets are used, apply another strip of black tape to top of folder, immediately to the left of the last four digits of the SSN. Never cover the prefix or SSN.

A3.2.1.6.2. Use black ink or a suitable marking device if black tape is not available. Stamp “FLY” in two-inch block letters in the upper left-hand corner of the front of the folder.

A3.2.1.7. Mark through the current year with a felt-tip marker or pen to indicate the latest year the non-active duty patient was treated. **NOTE:** Attach AF Form 665, **Health Record Year Grid**, to AF Form 2100A series. Do not prepare new folders.

A3.2.1.8. Blacken in the “outpatient” (or “medical” in editions before prior to 1980) block for all records.

A3.2.1.9. Indicate the patient’s status. Enter the Service and rank for extended active duty and retired military personnel. Enter the country for non-U.S. military personnel. Use pencil entries for items that change, such as rank. For family members who are also members of an ARC, enter the family member’s **own** SSAN here as well as their status as a member of the Air Force Reserve or Air National Guard as appropriate.

A3.2.1.10. If the person is a food handler, the physical examinations section enters the date of the current food handler examination in pencil on the appropriate line of the preprinted format.

A3.2.1.11. At points of entry into the Air Force, note “Antibodies: Measles_____, Rubella_____”. Use a stamp or pen.

A3.2.1.11.1. Enter the test results after “Measles” or “Rubella”. For example, if the patient is susceptible, mark “-“ after the disease named; if not susceptible, mark “+”.

A3.2.1.11.2. Enter date of serotesting in the left column.

A3.2.1.11.3. Note in the same way the records of medical personnel and others who have had an antibody screen against measles and rubella.

A3.2.1.12. If the patient is allergic to medication, display this information prominently under the patient identification data on the right-hand side of the folder.

A3.3. Filing Health Records.

A3.3.1. “Terminal Digit” Filing System:

A3.3.1.1. File records by SSN, according to a terminal digit, color-coded and blocked filing system. Divide the central files into 100 equal sections. Establish a minimum of file guides bearing the 100 primary numbers, “00” through “99”.

A3.3.1.1.1. Each section contains all the records whose terminal digits (last two numbers) correspond to that section's primary number.

A3.3.1.1.2. File folders in numerical sequence according to their secondary numbers within each section. The secondary number is the pair of digits immediately to the left of the primary number.

A3.3.1.2. Small facilities may maintain separate files for active duty and family members, if desired.

A3.3.2. All outpatient records and forms are maintained in a single numerical file in a central location except as authorized by the MTF Commander. Use AF Form 614, **Charge Out Record**, in the main file to indicate the location of the health record if decentralization is authorized. Records may be filed by organization for units that frequently transfer as a group.

A3.3.3. Manage ARC outpatient records as follows:

A3.3.3.1. Maintain records for members of ARC units (Category A) with their medical unit or element unless a local agreement exists with the collocated MTF to maintain the records. ARC medical record will not be interfiled with active duty medical records when maintained by an MTF. However, ARC medical records will be maintained in the same secured location as the active duty medical records when maintained by an MTF. The MPF maintains the unit's records when an ARC unit without their own medical unit or element is not collocated with an MTF.

A3.3.3.2. HQ ARPC/SG, Denver CO 80280-5000, maintains health records of reservists who are individual mobilization augmentees (IMA) or reinforcement designees (RD). (HQ ARPC/DS maintains the medical records of non-participating reserve members with the exception of retirees drawing pay.)

A3.3.3.3. Conduct an annual inventory of all ARC health records on file as of 31 March. HQ ARPC/DPM furnishes a list of the records identified in A3.3.3.2. Individual units furnish a list for personnel identified in A3.3.3.1. Notify appropriate personnel (ARPC) or the local unit in writing if records are not on hand. Medical records of non-participating reserve members are not subject to this annual inventory.

A3.3.4. Establish local procedures to inventory all other Active Duty records by 31 Mar. Rosters are obtained from the MPF.

A3.3.5. Family Advocacy records are maintained by the family advocacy officer for each individual in the family advocacy program. These files are separated from the outpatient record and are secured. Do not use the AF Form 2100A series for these records.

A3.3.6. ROTC, AFIT, and USAF Recruiting Service personnel and their family members may maintain their own medical records when the nearest MTF is not easily accessible.

A3.3.7. Special Cases.

A3.3.7.1. A person may be eligible for care in more than one status. For example, a person may be treated as a family member of an active duty person and may also receive treatment as a retiree. Maintain a cross-reference in the record files as well as in the patient index when a person is eligible for treatment in more than one status.

A3.3.7.2. In order to increase file space for outpatient records, it is permissible to split storage of records that consist of more than one volume. Place an AF Form 614 with the current volume to indicate the location of other volumes.

A3.3.7.3. Place outpatient records of deceased personnel in a separate secured file. Place an AF Form 614 in the central file to indicate the location of the record. **NOTE:** Use of AF Form 1942, to manage records is optional; however, prepare and maintain an AF Form 1942 for each record permanently forwarded or hand-carried to another facility. Keep the form in an alphabetical file, after its signed, for six months and then destroy.

A3.3.7.4. Record custodians comply with Air Force instructions when maintaining Army and Navy records.

A3.3.7.5. When personnel from the U.S. Army and U.S. Navy are:

A3.3.7.5.1. Attached to an Air Force facility for medical care, the Air Force assumes custody of their health records.

A3.3.7.5.2. Treated in an MTF but their records are not available, send documents ordinarily included in Air Force outpatient records to the custodian of their records. If unknown, forward these documents using guidelines provided in attachment 6.

A3.3.7.6. When Air Force personnel are treated at a U.S. Army or U.S. Navy facility:

A3.3.7.6.1. Send the records to the DoD medical treatment facility when Air Force personnel are attached there for primary medical care and the records are required for treatment.

A3.3.7.6.2. Insert documents received from the DoD medical treatment facility in the outpatient record.

A3.3.7.7. Interfile Army and Navy records with Air Force records. Replace folders with the AF Form 2100A series only if the color and blocking do not permit interfiling.

A3.3.8. Use embossed plastic cards or other tracking methods to record patient identification information on forms. The format will include, but is not limited to, patient name, family member prefix, SSN, facility name, and the name of the facility that maintains the record.

A3.3.9. Use SF 600, **Health Record – Chronological Record of Medical Care**, to document outpatient treatment. Enter the patient's name, family member prefix, SSN, facility name, and the name of the facility maintaining the record.

A3.4. Contents of the Outpatient Record.

A3.4.1. Each document in the record contains, as a minimum, patient's name, family member prefix, SSN under which the record is to be filed and name of the MTF maintaining the patient's record. An exception is the display sheet on which laboratory and x-ray slips are filed. Since the individual slips contain the necessary data, it is not necessary to repeat identification information on the sheet. The patient's mailing address may be added to any document.

A3.4.1.1. Documents will contain the name and location of the MTF maintaining the record, if other than the treating facility, to ensure document is sent to the proper MTF.

A3.4.1.2. Electronically generated forms (when used in place of SF, DD, or AF forms) must be a mirror image of the non-automated form and contain the statement “SF, DD or AF Form XXXX (EF) [name and producer/vendor (if any) of the software used].”

A3.4.1.3. Document in the patient’s record whether or not the patient has an advanced directive. Place advanced directives (Self-Determination Act forms) in an envelope and file in section 4 of the AF Form 2100A series folder and on the left side of the AF Form 2100 series folder as the last document. Annotate the DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flowsheet**, to indicate an advanced directive is filed and the date it was filed.

A3.4.1.4. File durable Power of Attorney forms and organ donation forms in section 4 of the AF Form 2100A series folder and on the left side of the AF Form 2100 series folder as one of the last documents.

A3.4.2. AF Form 2100 Series (Two-part folder). (Although no longer in print, there may still be some outpatient records that are filed in this style folder. This is acceptable. However, at such time the folder needs replacement, the AF Form 2100A Series (four-part) folder will be used. Additionally, the AF Form 2100A Series will be used to create folders on new patients.)

A3.4.2.1. Arrange documents on the right side of the folder in the following descending order:

A3.4.2.1.1. AF Form 745. This form identifies the records of individuals assigned to the PRP and the Presidential Support Program (PS). File the form so it is the uppermost item on the right side of the record. **NOTE:** Individuals may participate in more than one program. Facilities will circle the initials of the appropriate program on AF Form 745 (PRP and PS). Removal of the AF Form 745 depends on the number of programs with which the individual is associated. For example:

A3.4.2.1.1.1. For single program participants, the AF Form 745 will be removed and destroyed when the MTF program manager is notified by a base official the individual is no longer a participant.

A3.4.2.1.1.2. For dual program participants, do not remove the form unless notification has been received that the individual is removed from both programs. Line out only the affected program initials in black. In the case of reentry, replace the form and circle the initials. Destroy the old form.

A3.4.2.1.2. AF Form 966, **Registry Record**, is filed on top of the right side and under AF Form 745, if used.

A3.4.2.1.3. As additional SFs 600 are prepared, place each on top of the earlier one so the latest report of treatment is on top. Interfile SF 558 with SFs 600 in date order. DD Form 2161 is filed on top of the SF 600 to which it belongs.

A3.4.2.1.4. Laboratory Reports – mount on white bond paper arranging the forms to ensure that the results are readily visible without requiring the removal of staples. Patient ID is not needed on the bond paper.

A3.4.2.1.5. SF 519B, **Medical Record – Radiological Consultation Request Report** is filed in chronological order by date with the most recent on top.

A3.4.2.1.6. Ofs 520, **Medical Record-Electrocardiographic Record**, are filed together in chronological order by date (the most recent on top), except when Ofs 520 attached as docu-

mentation to reports, are filed with other reports. Filing a copy of the inpatient electrocardiograms (EKGs) in the outpatient record is optional. MTFs shall develop local policy to inform outpatient physicians of abnormal results of EKGs performed while a patient is in an inpatient status. Ensure OF 520 is filed so that the tracing can be read by the health care provider. Facilities with computer generated EKG reports may destroy OF 520 after the test has been ordered and if all patient identification is on the automated report.

A3.4.2.1.7. SF 78, **Certificate of Medical Examination**, (applies to civilian employees only) is kept in the employee's medical folder (SF 66D). When the employee is transferred, separated, or retired, send the entire record in a sealed envelope marked with the appropriate identification, to the MPF for inclusion in the employee's official personnel folder.

A3.4.2.2. Arrange forms on the left side of the folder in chronological sequence by the date of the most recent action. Folders with the preprinted Privacy Act Statement on the back will not have DD Form 2005 filed inside the record. Always file DD Form 2766 or AF Form 1480A, as the top form. **EXCEPTIONS:** ANG Medical Squadrons may file the (NGB Interim) Form 1480 on top for Air National Guard Members not Extended Active Duty or military family members.

A3.4.2.2.1. DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow-sheet** – original for active duty; use photocopy if deployed.

A3.4.2.2.2. DD Form 2766C or AF Form 1480B, **Continuation Sheet** – original for active duty; use photocopy if deployed.

A3.4.2.2.3. **Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM)** - original.

A3.4.2.2.4. **Results from HEAR**

A3.4.2.2.5. AF Form 1480, **Summary of Care** – original.

A3.4.2.2.6. AF Form 3922, **Adult Preventive Care – Flow Sheet** - original.

A3.4.2.2.7. AF Form 3923, **Child Preventive Care – Flow Sheets** – original.

A3.4.2.2.8. DD 2569, **Third Party Collection Program – Insurance Information** – original.

A3.4.2.2.9. AF Form 565, **Record of Inpatient Treatment**, (or CHCS computer generated form) – copy of original (or similar document used by U.S. Army, U.S. Navy, or Department of Veterans Affairs).

A3.4.2.2.10. AF Form 560, **Authorization and Treatment Statement**, used for nonmilitary hospital dispositions at clinics without CHCS. Previously filed AF Forms 560 will not be removed.

A3.4.2.2.11. SF 502, **Medical Record – Narrative Summary (Clinical Resume)** – copy of original report.

A3.4.2.2.12. SF 515, **Medical Record – Tissue Examination** – copy of original if inpatient report, original if outpatient report.

A3.4.2.2.13. SF 516, **Medical Record – Operation Report** – copy of original if inpatient report; original if outpatient report.

- A3.4.2.2.14. OF 517, **Clinical Record – Anesthesia** – copy of original inpatient report if there was an anesthetic incident; original if outpatient report.
- A3.4.2.2.15. Copy of all documentation relating to ambulatory surgery, including OF 522, **Medical Record – Request for Administration of Anesthesia and for Performance of Operations and Other Procedures**.
- A3.4.2.2.16. SF 602, **Health Record – Serology Record** – original.
- A3.4.2.2.17. SF 601, **Health Record – Immunization Record** – original (used by U.S. Army, U.S. Navy, Air National Guard, and U.S. Air Force Reserve).
- A3.4.2.2.18. AF Form 618, **Medical Board Report** – signed copy of original and associated documents.
- A3.4.2.2.19. AF 1721, **Spectacle Prescription** – copy of original.
- A3.4.2.2.20. A copy of the current AF Form 1042, **Medical Recommendation for Flying or Special Operational Duty**, AF Form 1418, **Recommendation for Flying or Special Operational Duty – Dental** – a copy of all AF Forms 1042 returning the individual to flying status, and a copy of any permanent suspension. File with the AF Form 1042 the SF 88 or any other form prepared in conjunction with AF Form 1042. Keep these supporting documents, even though AF Form 1042 may be destroyed. Remove the AF Form 1042 prepared for annual or incoming clearance from the file and destroy when it expires. AF Form 1042 excusing, grounding, or disqualifying the individual may be removed and destroyed when the AF Form 1042 returning the individual to flying status is filed.
- A3.4.2.2.21. SF 88, **Report of Medical Examination** – signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88, it is filed with the SF 88.
- A3.4.2.2.22. SF 93, **Report of Medical History** – signed copy of each report. File civilian employee's SF 93 in his/her health record.
- A3.4.2.2.23. DD Form 2216, **Hearing Conservation Data**, DD Form 2215, **Reference Audiogram**, and AF Form 1671, **Detailed Hearing Conservation Data Followup** – original of each.
- A3.4.2.2.24. Occupational environmental forms: AF Form 190, **Occupational Illness/Injury Report**; AF Form 1527, **History of Occupational Exposure to Ionizing Radiation**; AF Form 2755, **Master Workplace Exposure Data Summary**; AF Form 2769, **Supplemental Data Sheet**;
- A3.4.2.2.25. AF Form 348, **Line of Duty Determination**, (active duty military).
- A3.4.2.2.26. AF Form 422 **Physical Profile Serial Report**, (active duty military). The original AF Form 422 and all revisions of AF Form 422, whether temporary or permanent.
- A3.4.2.2.27. A copy of any document affecting aeronautical rating, designation, or flying status for medical reasons.
- A3.4.2.2.28. Other SF, DD, or AF Forms.
- A3.4.2.2.29. Other command or local health care forms approved by the command surgeon or medical facility commander.

A3.4.2.2.30. Other correspondence pertaining to the health care of the patient.

A3.4.2.2.31. AF Form 1352, **Hyperbaric Patient Information and Therapy Record** - original if treatment was on an outpatient basis.

A3.4.2.2.32. Copy of reports of health care requested from civilian sources (after being reviewed by the military provider).

A3.4.2.2.33. AF Form 1446, **Medical Examination – Flying Personnel** – signed original.

A3.4.2.2.34. AF Form 895, **Annual Medical Certificate (AMC)**.

A3.4.2.2.35. AF Form 137, **Footprint Record**.

A3.4.2.2.36. DD Form 2005, **Privacy Act Statement Health Care Records**, (in folders without preprinted PA statement).

A3.4.2.2.37. Advanced Directive (Self Determination Act forms), durable Power of Attorney forms, organ donor forms.

A3.4.3. AF Form 2100A Series, Health Record – Outpatient (Four-part folder) .

A3.4.3.1. The AF Form 2100A series is divided into four sections. Section 1 is located on the left side of the folder immediately inside the front cover, with the fastener at the bottom. Sections 2 and 3 are located on the middle flap of the folder, with fasteners at the top. Section 4 is located inside the back cover, with the fastener at the bottom. Folders are prepared for new patients, or when the present folder no longer protects the contents. Do not reaccomplish usable AF Form 2100 series folders.

A3.4.3.2. Arrange forms in section 1 in chronological sequence by the date of the most recent action. **Exceptions:** DD Form 2766 or AF Form 1480A is always the top form. ANG Medical Squadrons may file the (NGB Interim) Form 1480 on top for Air National Guard members not on Extended Active Duty or military family members.

A3.4.3.3. DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flowsheet** – original for active duty; use photocopy if deployed.

A3.4.3.4. DD Form 2766C or AF Form 1480B, **Continuation Sheet** – original for active duty; use photocopy if deployed.

A3.4.3.5. Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM) - original.

A3.4.3.6. Results from HEAR

A3.4.3.7. AF Form 1480, **Summary of Care** - original.

A3.4.3.8. AF Form 3922, **Adult Preventive Care Flow Sheet** - original.

A3.4.3.9. AF Form 3923, **Child Preventive Care Flow Sheets** - original.

A3.4.3.10. DD 2569, **Insurance Information** - original, unless reported in electronic format in an automated system.

A3.4.3.11. AF Form 565 (or approved CHCS computer generated form) - copy of original, or similar document used by the U.S. Army, U.S. Navy, Department of Veterans Affairs medical facilities

A3.4.3.12. AF Form 560 is used for nonmilitary hospital dispositions at clinics without CHCS. Previously filed AF Forms 560 will no be removed.

A3.4.3.13. SF 502 - copy of original.

A3.4.3.14. SF 509 - copy of original, when used as a final discharge note or discharge instruction.

A3.4.3.15. SF 515 - copy of original if inpatient report, original if outpatient.

A3.4.3.16. SF 516 - copy of original if inpatient report, original if outpatient.

A3.4.3.17. OF 517 - copy of original if inpatient report (if required), original if outpatient.

A3.4.3.18. Copy of all documentation relating to outpatient ambulatory surgery including SF 522.

A3.4.4. Arrange the forms in section 2 as follows:

A3.4.4.1. AF Form 745, when applicable, is always the top form of this section.

A3.4.4.2. AF Form 966 is placed on top of the documents and under AF Form 745 if used.

A3.4.4.3. SF 600 is filed in date order. Utilize both sides of the form. Interfile SF 558 with SF 600 in date order. File DD Form 2161 on top of the SF 600 to which it belongs.

A3.4.5. Arrange the forms in section 3 as follows:

A3.4.5.1. AF Form 422 is filed chronologically with most recent report on top.

A3.4.5.2. Arrange forms in chronological sequence by the date of the most recent action. **EXCEPTION:** AF Form 137 is filed on top of DD Form 2005 which is the bottom form in this section. **NOTE:** The September 1988 edition of AF Form 2100A series has the Privacy Act Statement printed on the folder. It is not required to place DD Form 2005 in these folders.

A3.4.5.3. Prenatal forms will be maintained in the OB-GYN clinic until the mother delivers. After delivery in the MTF, the prenatal forms will be filed as a package in the inpatient record. If the mother delivers in a civilian facility the forms will be filed in the outpatient record.

A3.4.5.4. File all other forms in chronological order by date, including letters and copies of reports of care from civilian sources (reviewed by the military health care provider).

A3.4.6. Arrange the forms in section 4 in *chronological order*, regardless of the type of report, with the most recent report on the top. *Exceptions* are as follows:

A3.4.6.1. Laboratory forms are stapled individually to bond paper. Computer generated reports may be grouped together and filed as the top forms in this section.

A3.4.6.2. SF 519b.

A3.4.6.3. OF 520, if used.

A3.4.6.4. Other tests.

A3.4.6.5. Advanced directives (Self Determination Act forms), durable Power of Attorney forms, organ donor forms.

A3.5. Documentation

A3.5.1. DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow Sheet**. This form provides the caregiver in the field with expanded medical data and ensures standards-of-care are

met. The priority populations to receive this form are mobility personnel, active duty, and adult beneficiaries, respectively. Utilize the hard stock version of the form for the active duty population. For all others, local reproduction of the electronic version will be used.

A3.5.1.1. All documentation will be completed in ink, except in sections III, *Medications*, and VII, *Screening Exams*. Section III may be completed in pencil. Section VII may be completed in pencil for the date the exam is ordered and ink when the exam is completed and the results are written.

A3.5.1.2. Information documented on the medical record is considered part of the legal document and is not to be discarded from the medical records at any time.

A3.5.1.3. Information will be transcribed from the AF Form 1480 onto the DD Form 2766 or AF Form 1480A in accordance with the AF Instructional Tool for AF Form 1480A, dated 12 September 1997. After transcribing the data, draw a line through the information and write the word "*Transcribed*" along the line with the date, full name, rank and AFSC of the transcribing individual. The AF Form 1480 will remain with the medical record. Place it behind the Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM) Report.

A3.5.1.4. Transcribe the AF Form 3922 information in the same way as the AF Form 1480. File this form after the AF Form 1480.

A3.5.2. DD Form 2766C or AF Form 1480B, **Adult Preventive and Chronic Care Flowsheet - Continuation Sheet**. This form is used as a continuation form for documenting information that cannot fit on DD Form 2766 or AF Form 1480A, or for local requirements. An automated version of the form is also utilized by the Military Immunization Tracking System (MITS) for documentation (reserved for documenting immunizations). Each time a member receives an immunization, the MITS will print an updated automated form. Discard the previous form after ensuring the latest contains all the immunization information.

A3.5.3. Photocopy DD Form 2766 or AF Form 1480A prior to deployment and keep the copy in the medical record which remains at the home base MTF. The original DD Form 2766 or AF Form 1480A folder will accompany the individual to the field. When a deployed member receives medical care, the SF 600 together with any other medical documentation created during the visit will be placed in the bracket inside the folder. On return to the home base MTF (after deployment), remove all documentation except for any DD Forms 2766C or AF Forms 1480B from the DD Form 2766 or AF Form 1480A folder and place it with the other documentation in the original medical record. Remove the photocopied DD Form 2766 or AF Form 1480A and shred it when the original is replaced into the record. Medical documentation created during deployment must be filed into the member's outpatient record within 30 days of the member's return to home base.

A3.5.4. Health Enrollment Assessment Review-Primary Care Manager (HEAR-PCM). The HEAR-PCM questionnaire is a required survey/questionnaire sent to the patient which requests information about clinical preventive tests. The patient is responsible for completing the survey and returning it to the individual's Primary Care Manager. The results are compiled in a format which provides recommendations of preventive services. The HEAR will be filed in the individual's outpatient record underneath the DD Form 2766C or AF Form 1480B.

Attachment 4**DISPOSITION OF SPECIFIC PATIENTS****A4.1. Discharge to Duty (Military Patient) or Discharge (Nonmilitary Patient).**

A4.1.1. Review the AF Form 577, **Patient's Clearance Record**, to ensure the patient has cleared all necessary sections. Annotate the form with the date and time of discharge and enter the information into the current automated system. The patient is then released from the MTF.

A4.1.2. Maintain the AF Form 577 in the Admission and Dispositions Office for a period of three months and then destroy.

A4.1.3. Remove any pertinent information from the suspense file and place in the patient's inpatient record. For active duty military personnel, information of a personnel nature is sent to the MPF for inclusion in the field personnel records.

A4.2. Discharging Nonactive Duty Patients Requiring Domiciliary or Custodial Care.

A4.2.1. Discharge retirees eligible for care in VA facilities as follows:

A4.2.1.1. Arrange for admission and transportation to a VA medical facility, if acceptable to the patient or Next of Kin (NOK).

A4.2.1.2. Release retirees declining assistance in getting into a VA facility to the NOK.

A4.2.1.3. If NOK declines acceptance, contact civil authorities in the patient's state of residence for permission to transfer the patient to their custody. If the original request for permission is disapproved, repeat the procedure with civil authorities of the state where the patient entered the Service (when different from the state of residence).

A4.2.1.4. Provide complete information from the attending health care provider (in narrative form) on the diagnosis, date the condition started, history of previous hospitalization(s) for the condition, patient's legal residence, place and date of birth, length of patient's military service, and name and address of patient's NOK.

A4.2.1.5. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

A4.2.2. Discharge other non-active duty patients requiring domiciliary or custodial care following procedures similar to those in paragraph A4.1 and A4.2.1.

A4.2.2.1. Discharge alternatives must be acceptable to the patient or NOK.

A4.2.2.2. Release the patient to the NOK if the arranged or recommended alternatives are declined.

A4.2.2.3. Request permission to transfer patient custody to civil authorities if the NOK declines acceptance. Contact the SJA if the request is denied.

A4.3. Discharging Patients Not Eligible for Care at VA Expense.

A4.3.1. Discharge a military patient who, upon expiration of term of service (ETS), has physical or mental disabilities as follows:

A4.3.1.1. Contact the NOK to determine whether they are assuming custody of the patient and responsibility for care (see A4.4).

A4.3.1.2. The NOK must produce affidavits certifying their willingness to make suitable arrangements for the patient and the financial means to do so.

A4.3.1.3. See A4.2.1.3 – A4.2.1.4 for procedures to follow when NOK declines acceptance.

A4.3.1.4. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

A4.3.2. Discharge a civilian patient with a physical or mental disability requiring hospital care beyond that authorized in an Air Force medical treatment facility in accordance with A4.3.1 if he or she is not a beneficiary under the Federal Employees' Compensation Act. Coordinate proposals to move a civilian employee hospitalized in a medical facility outside the U.S., or to separate him or her for medical or other reasons, with the appropriate Civilian Personnel Officer.

A4.4. Discharging Patients With Chronic Physical or Mental Conditions. The following instructions apply to a civilian or military member who is separated or retired because of a chronic physical or mental condition.

A4.4.1. A patient who does not exhibit suicidal or homicidal tendencies may request release to the NOK (see A4.3.1.2).

A4.4.2. Discharge a patient who exhibits suicidal or homicidal tendencies as follows:

A4.4.2.1. Transfer a member or former member of the Armed Forces entitled to treatment by the VA to a location designated by the VA. This requires the request of the NOK and authorization for admission from the hospital concerned.

A4.4.2.2. Discharge a military or civilian patient not entitled to treatment by the VA to civil authorities who are legally authorized to assume care in such case; to the Federal Bureau of Prisons, if treatment there is authorized; or to an acceptable private hospital at the written request of the NOK. This will also require authorization from the destination hospital.

A4.4.3. A non-military psychotic patient admitted to an Air Force medical treatment facility overseas is handled by the liaison, through the American Embassy and civil authorities, to resolve problems associated with hospitalization and transfer to CONUS.

A4.4.3.1. By law, the Department of Health and Human Services (HHS) may receive and provide care for nonmilitary mental patients returned to CONUS.

A4.4.3.2. If the patient is not releasable to the NOK, and is not authorized further Air Force hospitalization, the overseas commander asks local U.S. diplomatic representatives to arrange, through the Department of State, for the HHS to receive the patient upon arrival in CONUS.

A4.4.4. For instructions on the discharge of psychotic prisoner patients see A4.5.1.

A4.5. Disposition of Prisoner Patient. When discharging prisoner patients, the Federal Bureau of Prisons exercises administrative control over Air Force prisoners confined in a DoD regional or long-term corrections facility. This agency's responsibility extends to all matters except clemency, parole, restoration to duty and enlistment. When a prisoner is under the administrative control of the Air Force, the Air Force is responsible as follows:

A4.5.1. If a prisoner, whose sentence includes an executed punitive discharge, has a disabling condition (including psychosis requiring closed unit treatment), hospitalize the prisoner at the nearest Air Force or Army hospital which can provide the required care. Move the patient in accordance with AFI 31-205, *Corrections Program* and AFJI 41-315, *Patient Regulating To and Within the Continental United States*.

A4.6. Discharging Patients With Communicable Diseases. Notify military public health if a military patient has a communicable disease when the term of service ends and he or she elects to separate and be discharged from the hospital. Also notify the local health officers having jurisdiction in the area adjacent to the military installation and in the community to which the patient is proceeding. For nonmilitary patients with a communicable disease being discharged from the hospital, also notify local health officers.

A4.7. Discharging Nonactive Duty Patients Refusing to Comply with Rules. Contact the SJA for assistance when a nonactive duty patient fails or refuses to comply with established rules.

A4.8. Discharging Patients With Terminal Illness.

A4.8.1. Transfer non Air Force members according to AFJI 41-315 for movement to a MTF with the authority to discharge them

A4.8.2. Ensure terminal patients receive optimum MTF benefits. Final decision on the discharge of the patient depends on MTF capability, demand for services and humanitarian considerations.

A4.8.3. If the active duty terminal patient is referred to the PEB, follow the procedures in AFIs 48-123 and 36-3212, *Physical Examination for Retention, Retirement and Separation*.

A4.9. Discharging Patients Absent Without Leave (AWOL). Report a military patient who is AWOL from a medical facility to the individual's servicing MPF. Do not carry AWOL patients on the Admissions and Dispositions (A&D) list or the census reports more than 10 days. Close out the medical records after 10 days.

A4.10. Discharging Patients Through Action by MEB and PEB. See AFIs 48-123 and 36-3212.

A4.11. Subsisting Out (SO). Health care providers may release military patients from occupying a bed and continue to provide them treatment in an excused-from-duty status by completing AF Form 569, **Patient's Absence Record**. The provider sees the patient frequently, annotates progress notes and appropriately dispositions the patient once treatment is completed.

A4.11.1. Notify the patient's unit commander and the MPF responsible for pay administration via the A&D list or other appropriate method.

A4.11.2. Clear the patient from the hospital as though being discharged to duty. Compile the inpatient record and send it to the disposition clerk, but do not finalize the record. Maintain the record in the suspense file in the A&D section (or in clinic services depending on local procedures) for availability to treating personnel until the patient returns to the hospital or is discharged from the provider's care. At that point, follow instructions regarding processing of records. (See A4.1)

A4.11.3. List the patient as SO in reports, records and census rather than a bed occupant for the treatment period.

A4.11.4. The patient may live in bachelor/unaccompanied quarters or at home. (If the patient lives alone or is in bachelor quarters, he or she must have the consent of their unit commander.)

A4.12. Convalescing Patients. Grant convalescent leave to military patients in accordance with AFI 36-3003.

A4.12.1. MTF commanders may approve convalescent leave up to a total of 90 days for a single period of hospitalization. Convalescent leave over 30 days requires additional medical review and consent with the exception of obstetrical leave (see A4.12.2). Convalescent leave in excess of 90 days must be approved by the MAJCOM Surgeon's Office.

A4.12.2. The attending health care provider may grant up to 42 days of postpartum convalescent leave upon discharge, unless the mother's medical condition warrants a longer period.

A4.12.3. The discharge clerk coordinates all arrangements for an inpatient's departure on leave. AF Form 988, **Leave Request/Authorization**, is cleared through the discharge clerk

A4.12.4. For directed convalescent leave, the health care provider completes and signs Block 7 and the chief of service reviews and approves the leave by signing in the "Remarks" section of Block 8 of the AF Form 988. The patient squadron section commander completes Blocks 23 through 25.

A4.12.4.1. The inpatient record remains open while the patient is on convalescent leave and is held in the suspense file in A&D until the patient returns. The record is then returned with the patient to the assigned unit or forwarded to the Inpatient Records department if the patient is discharged.

A4.12.5. For recommended convalescent leave, procedures are the same as in A4.12.4, except the patient's squadron section commander completes Blocks 22 through 25 on the AF Form 988. In addition, the inpatient record is closed out upon discharge to convalescent leave.

A4.12.5.1. Except as provided in A4.12.2, squadron section commanders may approve initial convalescent leave up to 30 days. Further approval of convalescent leave beyond 30 days requires additional medical review and consent.

A4.12.5.2. Recommendations for convalescence are also used for outpatients (without related inpatient episode) when the medical condition warrants it.

A4.12.5.3. Convalescent leave is not to be used as an alternative for placing a member in an excused from duty status or when an individual could instead be returned to limited duty without adversely affecting full recovery.

A4.13. Retention of Enlisted Patient Beyond the Discharge Date. See AFI 36-3208, *Administrative Separation of Airmen*.

A4.14. Discharging Persons Refusing Professional Care.

A4.14.1. An MEB must evaluate any military member refusing to submit to medical, surgical, or dental treatment or diagnostic procedures. If the refusal is based on religious grounds, arrange for the appointment of a military chaplain as an additional member of the board. The board determines if:

A4.14.1.1. The individual needs the procedure in order to properly perform military duties or establish medical qualification for continued service.

A4.14.1.2. The procedure, according to accepted medical or dental principle, will produce the desired results

A4.14.1.3. When the decision on both points is affirmative, the individual is informed that the treatment is required. If the individual still refuses the procedure, send the MEB proceedings to HQ AFPC/DPAM, Randolph AFB TX 78150-5001, for review and disposition recommendations or instructions. **NOTE:** When an emergency diagnostic or therapeutic measure is required to save the patient's life or limb, it may be performed without the patient's permission. It may also be performed when necessary to protect the health of a patient declared mentally incompetent by a qualified psychiatrist.

A4.14.2. Notations are placed in the health record documenting the refusal and explaining the risks of refusal that were provided to the patient. Beneficiaries are encouraged to sign the notation.

Attachment 5**TRANSFERRING PATIENTS**

A5.1. Transferring Patients Between Military Medical Treatment Facilities. See AFJI 41-315, for guidance on moving an authorized non-military patient.

A5.1.1. Move military patients from one MTF to another at the discretion of the MTF Commander. Evacuate patients outside the CONUS who require 90 or more days of hospitalization to a CONUS MTF. MAJCOM surgeons overseas may move a patient to the CONUS if:

A5.1.1.1. Hospitalization of more than 90 days is expected.

A5.1.1.2. Specialized care cannot be provided by local U.S. government agencies.

A5.1.1.3. Return to duty is not expected.

A5.1.1.4. Patients under consideration for separation for other than disability may only be transferred to CONUS if, after receiving optimum treatment and evaluation in theater, further care and treatment is required.

A5.1.2. Orders moving Air Force military patients on a temporary duty status must also provide for returning the patient to the proper organization upon release from the MTF (see AFI 65-103, *Temporary Duty Orders*). Orders must cite the appropriation to which the travel is chargeable. If the discharged patient is not returned to his or her organization, the receiving MTF notifies the transferring MTF.

A5.2. Transferring Patients for Humanitarian Reasons A patient may be moved from one hospital to another for administrative or humanitarian reasons rather than medical (See AFJI 41-315). The MTF Commander submits a written request to AFMOA/SGOC, Bolling AFB DC 20332-7050 stating the following:

A5.2.1. Patient's full name and, for military personnel, the grade, SSN and unit of assignment.

A5.2.2. Diagnosis, prognosis, present condition, probable date and type of disposition contemplated; if a terminal case, state life expectancy.

A5.2.3. Statement on specialized treatment required. If none, so state.

A5.2.4. Patient's home address.

A5.2.5. For military patient, provide a statement if patient may be required to appear before a physical evaluation board.

A5.2.6. Location of receiving DoD hospital and name of accepting provider.

A5.2.7. Description of circumstances on which request is based.

A5.2.8. Other pertinent information.

A5.3. Transferring Patients to Another Military Hospital Within the United States or to a VA Hospital or a VA Designated Community Nursing Home:

A5.3.1. Transfer patients (military or nonmilitary) requiring specialized treatment not available at the CONUS Air Force medical treatment facility to an appropriate MTF.

A5.3.2. Transfer active duty patients eligible for required hospitalization in a VA hospital (or VA-designated community nursing home) after separation or retirement to designated facility for further hospitalization or nursing home care.

A5.3.3. The health care provider submits AF Form 230, **Request for Patient Transfer**, to the chief of service for approval. Send the form to the office responsible for aeromedical evacuation or patient movement upon approval.

A5.3.4. Transfer the patient in accordance with AFI 48-123 and AFJI 41-315.

A5.3.5. If transferring the patient to a VA Hospital, prepare DD Form 675, **Receipt for Record and Patient's Property** (four copies). The responsible officer of the receiving facility signs the original copy and returns it to the originating military hospital.

A5.4. Transferring Drug and Alcohol Abuse Patients to VA Hospital. All CONUS MTFs and overseas facilities listed below are authorized to transfer drug and alcohol abuse patients to VA hospitals.

Hospitals:

Incirlik AB, Turkey

Kunsan AB, Korea

Osan AB, Korea

RAF Lakenheath, England

Misawa AB, Japan

Clinics:

Andersen AFB, Guam

Hickam AFB, Hawaii

Kadena AB, Okinawa

NOTE: Include, in copy of patient's health records, the complete name and address of the MTF gaining administrative responsibility for the patient and a summary of the patient's case.

A5.5. Transferring Military Patients to a Non-Military Hospital (Other Than VA) for Treatment:

A5.5.1. The health care provider submits AF Form 230 to the office responsible for aeromedical evacuation or patient movement for notification of proposed transfer of the patient to a non-military hospital for treatment. After the non-military facility has agreed to the transfer, arrange for the movement of the patient.

A5.5.2. Send copies of pertinent portions of the inpatient records with the patient. Compile the original record and maintain in a suspense file until either the patient is discharged from the non-military hospital or returned to the MTF for further treatment.

A5.5.3. Follow guidelines in para 5.3 for administrative responsibility while the patient is in the non-military facility.

Attachment 6**OUTPATIENT RECORDS MAINTENANCE**

A6.1. Using Charge Out Guides. Use AF Forms 885, 886, and 887. **Medical Record Charge Out Guides**, and AF Form 250, **Health Record Charge Out Guide Request**, to show the location of an outpatient record removed from the file.

A6.2. Loaning Records to Clinics/Units. Establish strict procedures to manage the loaning of records. These procedures will:

A6.2.1. Limit access to all outpatient records areas.

A6.2.2. Require consistent use of charge out guides and accurate, complete information on AF Form 250.

A6.2.3. If possible, the outpatient records section will send the outpatient record in advance to the clinic at which the patient has an appointment.

A6.2.4. When a patient without an appointment arrives at a clinic without his or her outpatient record, an AF Form 250 or other appropriate form is prepared. This completed form is presented to Outpatient Records and the patient's record is removed from the file and given to the patient or sent to the clinic.

A6.2.5. If a record is involved in a potential claim, do not give the original record to the patient.

A6.2.6. Establish specific time criteria for records return and follow-up actions to retrieve delinquent records.

A6.2.7. Require that retirees' and family members' outpatient records be retrieved and maintained in the MTF.

A6.3. Requesting Records.

A6.3.1. Patients requesting their records at the outpatient records section must complete an AF Form 250 or other prescribed form. Inform them of the records control policy. Take action to retrieve the record if the record is not returned.

A6.3.2. Clinic clerks are responsible for obtaining records for patients treated in their clinics. Clinic clerks must complete AF Form 250 to check out a record. Outpatient records will remain in the clinic until the patient is discharged or the record is no longer needed. Records from the clinic are to be returned to the outpatient records room at the end of the day.

A6.4. Quality Control of Records Maintenance. In addition to the fact that medical records are the property of the Government and their maintenance at the MTF is a legal requirement, there is an increasing requirement that these records be available to the many accrediting and auditing agencies who review records. The lack of medical records and medical record documentation may adversely impact JCAHO accreditation and MTF funding.

A6.4.1. MTFs will implement a system to ensure 90% availability and accountability of outpatient medical records by establishing local tracking and retrieval procedures.

A6.4.2. At a minimum, these procedures must include a monthly review of charged-out records and a methodology to retrieve those records charged out.

A6.4.3. The MTF will establish procedures to regain custody of those outpatient records which are being maintained by the patient.

A6.4.4. The MTF staff and the patients must be educated on the importance of and reasons why records must be maintained by the MTF (e.g., briefing at staff training and education sessions, Town Hall meeting with patients, patient newsletters, etc).

A6.4.5. Just as important as the availability of records is the completeness of the documentation in those records. Therefore, MTFs will establish procedures to ensure that records contain accurate and complete documentation of outpatient visits.

A6.5. Filing Outpatient Computer Generated Clinical Encounter Results . Daily filing of outpatient test results is no longer a requirement as the result of on-line capability through clinical computer data bases. Develop local policies and procedures to ensure complete cumulative test results are printed and inserted in the outpatient records when appropriate and necessary (e.g., referral for medical care, PCS, etc.). Develop methods to ensure all test results (including archived results) are retrieved and filed when the record is retired to the National Personnel Records Center, the Department of Veterans Affairs, or the MTF deems it necessary for the record to contain the hard copy test results. MTFs discontinuing the daily filing of outpatient laboratory and radiology test results must follow these guidelines:

A6.5.1. Determine if there are state laws that require the maintenance of hard copy test results or that prohibit the storage of these results in electronic media only. There are no federal laws prohibiting the storage of test results in electronic media. The MTF may implement this practice if there are no state laws.

A6.5.2. Consult and obtain agreement with the professional staff. Providers must have access to all test results on demand. The professional staff must comprehend they will no longer find hard copy test results in the outpatient records on a routine basis. Instead, authorized users may obtain the results from the CHCS interactive computer terminals. Ensure confidentiality of the data by following all applicable DoD and Air Force security regulations. The system manager at each MTF is responsible for controlling and issuing accounts giving authorized users access to test results or other patient data.

A6.5.3. It is essential that the outpatient record section coordinate with the MTF system manager to determine the optimal time and retrieval methods for on-line and archived data. Make arrangements for systems personnel to be on hand to assist in the retrieval of the archived data. Make every effort to ensure complete documentation is obtained on the cumulative printouts, especially archived data.

A6.5.4. Test results are archived after a facility specified time (usually 18 months). Retrieval of archived data is a lengthy process and best performed on weekends. Take these time considerations into account when preparing records for retirement, transfer, or appointments made with provider who do not have access to the CHCS data base.

A6.6. Handling Loose Medical Documentation . File loose documents in the outpatient record as soon as possible. Documents received after the record is charged out are placed temporarily in the pocket of the charge out guide.

A6.6.1. Proceed as follows when loose documents are received and there is no charge out guide or record in the file:

A6.6.1.1. Active Duty Air Force. Maintain a Worldwide Locator (WWL) microfiche list of active duty and retired personnel in the Outpatient Records Section. If the person is listed, send the documents to the MTF at the base to which the patient is assigned. Send any documents or records for separating or retiring Air Force personnel to the local MPF no later than five duty days after the member's DOS. If more than five duty days, send the health records and/or loose documentation (in an outpatient folder) for members not filing a claim directly to the Department of Veterans Affairs, Service Medical Records Center, P.O. Box 150950, St. Louis, MO, 63115-8960. Send health records and/or loose documentation (in an outpatient folder) for members who are filing a claim to the VA regional office where the member has filed for compensation or pension. Prepare DD Form 675, **Receipt for Records and Patient's Property**, to forward records and loose documents to the VA regional office or VA service medical records center. Coordinate with the MPF to determine where health records and/or loose documents are to be sent.

A6.6.1.2. Family Members, Retired, and Other Non-Military Personnel. Records of Air Force active duty family members are usually maintained at the MTF where the sponsor is assigned unless it is an unaccompanied tour. Check the WWL to ascertain where the sponsor is assigned. If it can be determined that the sponsor's family members receive care at the MTF, forward the loose documents for inclusion in the outpatient record. In all other cases where the record cannot be located, file the loose documents in a charge-out guide. If the record is not located within three months, place the documents in a manila folder annotated with the patient's identification, and file in place of the charge out guide. These records will be retired in accordance with AFI 37-138.

A6.6.2. Return a document with incomplete patient identification to the originating clinic for completion.

A6.6.3. Develop local procedures between clinic and ancillary services personnel to correct errors and avoid omissions. Do not ask the patient to return an improperly completed form to the originator.

A6.6.4. If the clinic cannot sufficiently identify the documents for filing, notify the committee responsible for medical records review, the chief of the medical staff, or to the MTF quality committee in order to resolve the problem. Unfileable medical documentation may be destroyed at the direction of either.

A6.7. Withdrawing Documents . When documents in an outpatient record are relevant to further treatment as an inpatient, the documents may be withdrawn and inserted in the inpatient record. Note the withdrawal on SF 600.

A6.8. Emergency Room Records . Document emergency room (ER) visits on SF 558 or its equivalent (See A9.4.1.4).

A6.8.1. Facilities using the ER to provide routine follow-up treatment may use SF 600 instead of SF 558. MTFs using this option should prepare a directive explaining the process.

A6.8.2. Send the original SF 558 to the inpatient unit and file in the inpatient record if the patient is admitted. File the original SF 558 in the outpatient record if the patient is treated as an outpatient. File the second copy of the form in the ER. Give the third copy to the patient. Establish local procedures to safeguard the ER copies of SFS 558 pertaining to highly sensitive issues.

A6.9. Transferring Outpatient Records . Outpatient records personnel are responsible for forwarding of all health record and/or loose medical documents to arrive at the MPF by their established suspense date. Send a letter to the MPF ([figure a6.1.](#)) if the record is not available. See A6.6.1. for forwarding health records and/or loose medical documents for separating or retiring members. The patient may be given an abstract of the case, or copies of pertinent pages, if the provider believes future medical care is needed. Place the record in a sealed envelope stamped or otherwise marked “Sensitive Information, For Eyes Only of New MTF Commander” if it is determined that the person’s physical or mental health would be injured if he/she reviews the record. Inform the MPF that the records are not to be handcarried by the person concerned (see AFI 36-2608, *Military Personnel Records Systems*).

A6.10. Sending Loose Documentation or Medical Records After Departure . Use these procedures if loose documents or complete outpatient records are found after the outpatient records are sent:

A6.10.1. Send U.S. Air Force records or documents to HQ AFPC/RMIQL, 550 C Street West, Suite 50, Randolph AFB, TX 78150-6001. **Note:** This should only be done when location shown on WWL is data masked, or the records were returned from the base due to member not arriving.

A6.10.2. Send U.S. Army records or documents as follows:

A6.10.2.1. Active duty officer, warrant officer, and enlisted records to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 96249-5301.

A6.10.2.2. Records for retired personnel to the Commander, ARPC, 9700 Page Boulevard, St. Louis MO 63132-5200.

A6.10.3. For U.S. Navy records and documents, send a letter with the active duty member or retiree sponsor’s name and SSN to the Department of the Navy, Navy Personnel Command, PERS-312F, 5720 Integrity Drive, Millington, TN 38055-3120 or fax to (910) 874-2766, DSN 882-2766. In addition to providing the most recent address, the Navy Worldwide Locator Service will be able to advise if the documents should be retired to NPRC or the DVA RMC. Dispose of records of family members and retired Navy personnel in the same manner as AF family members and retirees.

A6.10.4. For U.S Marine Corps active duty members, forward the stray or lost medical records or forms to the USMC Worldwide Locator Service, Commandant of the Marine Corps, Headquarters USMC, 2008 Elliot road, Suite 215, Quantico, VA 22134.

A6.10.5. For Public Health Service or Coast Guard commissioned corps records or forms with a complete name and SSN, forward to Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4-35, Rockville, MD 20857-0435.

A6.10.6. For National Oceanic and Atmospheric Administration (NOAA) records of forms with a complete name and SSN, forward to Commissioned Personnel Center, NOAA (ATTN: CP01), 11400 Rockville Pike, Room 108, Rockville, MD 20852-3004.

A6.10.7. For ARC records or documents, if the member’s ARC unit is unknown, contact the appropriate ARC/SG (see Terms - Atch 1, Section C) for further instructions.

A6.11. Forwarding Nonmilitary and Retired Military Outpatient Records .

A6.11.1. Records may be given to the person to whom they pertain or, in the case of minor children, to a parent or legal guardian for delivery to the next DoD medical treatment facility. Mail the record if the provider believes the person's physical or mental health would be injured if he/she reviews the record. The provider may authorize copies or prepare an abstract of pertinent medical documents to be given to the patient. The patient concerned, a parent or legal guardian or minor children, or other persons authorized by the patient, must sign for the records using AF Form 1942.

A6.11.2. Do not release an adult family member's record to anyone else except as authorized by AFI 33-332.

A6.11.3. Place the record in a sealed envelope addressed to the gaining MTF when AF Form 1942 is properly completed. Annotate and file AF Form 1942 as specified in attachment 3 (see the "note" in A3.3.7.3).

A6.12. Transferring Outpatient Records by Mail:

A6.12.1. Mail outpatient records to another DoD medical treatment facility upon receipt of a DD Form 2138, DD Form 877, or other legal request.

A6.12.2. Initiate the DD Form 2138 for active duty and retired members and their family members if a record is mailed. The individual delivers the form to the new MTF. The receiving MTF completes the remaining sections of the form and sends to the losing MTF.

A6.12.3. The sending MTF prepares AF Form 1942, and files it in the inactive file of index cards for six months. Insert charge out guide with a copy of PCS orders, DD Form 877, or DD Form 2138. File all loose medical documents in the appropriate charge out guide. Store loose documents no more than 90 days, then mail to the receiving MTF.

A6.12.4. When individuals who are not attached to the base are receiving medical care on base (for example, AFIT students), identify their records by entering their status on the record folder, in pencil. Do not forward these records except at the patient's specific request.

A6.13. Retiring Outpatient Records of Nonmilitary and Retired Military Personnel. Retire outpatient records for nonmilitary and retired personnel at the end of each calendar year in accordance with AFI 37-138 and AFMAN 37-139. Dispose of the records of allied and neutral military personnel in accordance with the same directives.

Figure A6.1. Sample Format—Letter to MPF Concerning Missing Outpatient Medical Records.

(Medical treatment Facility Letterhead)

MEMORANDUM FOR APPROPRIATE MPF/DPMUO

FROM: (Insert the appropriate hospital designation here.)

SUBJECT: Missing Outpatient Records

The outpatient records for _____ (name, rank, SSN) of _____ (organization) are not available at this time. A thorough search will be conducted and the records will be forwarded to your office if found prior to the member's estimated departure date. We will contact your office to determine appropriate disposition.

(Appropriate duty title of individual signing the letter, i.e., NCOIC, Outpatient Records)

Attachment 7

CASUALTY REPORTING

A7.1. Assigning Responsibility.

A7.1.1. The patient's attending health care provider classifies a patient as VSI, SI or III and records an entry on the AF Form 3066 (or 3066-1), **Doctor's Orders**. This prompts preparation of an AF Form 570, Notification of Patient's Medical Status, which is sent to the locally designated casualty affairs liaison (CAL).

A7.1.2. Upon receiving the AF Form 570, the CAL completes section V and immediately notifies the installation commander and/or Casualty Assistance Representative (CAR) in accordance with AFI 36-3002. The CAL provides enough information to make the first notification and required progress reports on the patient's status.

A7.1.3. For personnel in a VSI, SI, III or NSI casualty status, the attending physician, MTF Commander, member's commander, or designated representative or HQ AFPC/DPWCS notifies the NOK, by telephone if necessary.

A7.2. Procedures for Travel of the Next of Kin (NOK) Under the Invitation Travel Order (ITO) Program. The attending provider provides a recommendation to the MTF Commander that the presence of the NOK is considered beneficial to the patient's recovery. If the MTF Commander approves the request the CAL (or after duty hours the administrative/noncommissioned officer of the day) immediately contacts the CAR, who is responsible for contacting AFPC/DPWCS for authorization/publication of ITOs, providing the information necessary to request transportation. Full explanation of the ITO Program is in AFI 36-3002.

A7.2.1. The commander or head of the Air Force medical treatment facility must concur and approve the attending physician's request on AF Form 570 prior to HQ AFPC/DPWCS issuing the ITO.

A7.2.2. ITO approval authority may not be delegated.

A7.3. Preparing the AF Form 1403, Roster of Seriously Ill/Very Seriously Ill. The CAL prepares AF Form 1403 each day as of midnight to cover the preceding 24-hour period. Negative rosters are not required. Distribute the AF Form 1403 in accordance with local guidance and AFI 37-124, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*.

A7.4. Providing Follow-up Information. The CAL provides the installation commander and CAR with information received from the patient's health care provider for follow-up action in accordance with AFI 36-3002.

A7.5. Removing Patients from the Roster.

A7.5.1. When the attending health care provider determines that the patient can be removed from the Roster of Seriously Ill/Very Seriously Ill prepare AF Form 570 and send it to the CAL.

A7.5.2. The CAL will notify the installation commander and CAR once the patient is removed from the roster so that action can be taken in accordance with AFI 36-3002. Notify interested persons or

agencies, as defined by local guidance, quickly and complete Section V of AF Form 570. File AF Form 570 in the patient's suspense file. Annotate the remarks section of the work copy of the AF Form 1403 to show the time of removal.

Attachment 8

BIRTH REGISTRATION

A8.1. Registering Births Overseas. Overseas Air Force medical treatment facilities must cooperate with consular officers in registering births of infants born to U.S. citizens in areas overseas. **EXCEPTION:** Register births in American Samoa, Guam, Puerto Rico, the Trust Territories, and the U.S. Virgin Islands through the special offices of the Vital Statistics Division, Public Health Service, U.S. Department of Health and Human Services, or specified local U.S. Government offices.

A8.2. Reporting Births. Births are reported to local authorities on the forms provided by U.S. Consular Offices.

A8.3. Notifying the U.S. Consular Office. Notify the U.S. Consular Office where the Air Force medical treatment facility is located no later than 10 days after the birth of an infant whose parent or parents are U.S. citizens.

A8.4. Completing Department of State Foreign Forms FS-240, Consular Report of Birth Abroad of a Citizen of the United States of America. The FS-240 will be completed in four copies. The (U.S. citizen) parent will sign each copy of the forms under oath before a military officer qualified to administer oaths. The officer administering the oath completes the section reading, "This section to be completed by consular officer, notary public or other person qualified to administer oaths." **NOTE:** Obtain a supply of FS-240s from the nearest U.S. Consular Office.

A8.4.1. If the mother is not a U.S. citizen, the U.S. citizen father must sign FS-240 if he is available. If the father is not available (or if there is any question about his citizenship status), ask the parent(s) to get in touch with the U.S. Consular Office.

A8.4.2. If the mother dies or is in very serious condition and the father, who is a U.S. citizen, is not available, send the FS-240 to the U.S. Consular Office as soon as the health care provider delivering the infant signs the form to attest the delivery.

A8.4.3. Contact the nearest U.S. Consular Office concerning necessary procedures to establish U.S. citizenship when a child is born out of wedlock.

A8.4.4. Advise the parents about the following procedures:

A8.4.4.1. If the U.S. citizen parents have the proper documentation to support entries on FS-240, inform them that they need not go to the U.S. Consular Office in person.

A8.4.4.2. If the necessary documentation is questionable or not available, send the FS-240 to the U.S. Consular Office and advise the parents to visit the office with documents establishing marriage and citizenship.

A8.4.5. In addition to proving birth fact, the U.S. Consular approved FS-240 is considered full proof of U.S. citizenship in all courts, tribunals and public offices of the U.S., both inside and outside the CONUS; the District of Columbia; and each state, territory, and outlying possession of the U.S. The FS-240 is equal to the certificate of citizenship or naturalization that the U.S. Immigration and Naturalization Service (USINS) issues.

A8.5. Certificate of Birth, FS-545 (also known as DS-1350 in the U.S). Obtain information from the FS-240 to prepare the Certification of Birth. This certification is a short form record of birth that the Department of State uses to provide persons born outside the CONUS and its possessions with a birth certificate form similar to those that State Vital Statistics Registration Offices in the U.S. issue. However, this Certification of Birth does not replace the FS-240 in any way.

A8.6. Registration of Birth. Advise the parents that a fee for registering the child's birth will be charged. The U.S. Consular Officer issues them a copy of the FS-240 when the birth is reported, as well as a copy of the FS-545.

A8.7. Additional Copies of FS-240 and FS-545. Parents, or the child at a later date, can obtain additional copies of the FS-240 and FS-545 from the Office of Passport Services, Correspondence Branch, Suite 510, 1111 19th Street, N.W., Washington, DC 20522-1705. The current phone number, as of 1997, is (202) 647-0518 and the current fee, as of 1997, is \$10 per certified copy. Make the check or money order payable to the Department of State.

A8.8. Updating Personnel Records. Advise DoD personnel whose children are born overseas to report to the Military Personnel Flight to update personnel records and enroll the child in the DEERS as part of birth registration in an overseas area. This is also required in the CONUS.

A8.9. Birth Registration in the CONUS. A birth certificate will be prepared for each infant born in an Air Force medical treatment facility. Follow State laws with regard to the forms used, format, and number of copies required. File an additional copy in the infant's inpatient record

Attachment 9

CONTENTS OF INPATIENT RECORD

A9.1. Arranging the Contents of the Inpatient Record. On disposition of the patient, arrange paper copies of forms in the order listed below as applicable to the case. **NOTE:** Upon development of the computer-based patient record, the arrangement of data in the electronic record may vary from the guidance provided here. An asterisk “*” denotes that the form may not be filed in the order listed. See instruction column for proper filing location. **NOTE:** Command and locally developed medical forms should be filed in the appropriate order as according to purpose.

Form Number and Title	Instructions
AF Form 565, Record of Inpatient Treatment AF Form 560, Authorization and Treatment Statement SF 569, Patient's Absence Record *AF Form 618, Medical Board Report	Original, typed, or electronic. Original With attachments as a complete package when prepared. Unless included in Medical Board package.
SF 502, Medical Record-Narrative Summary (Clinical Resume) SF 503, Medical Record-Autopsy Protocol DD Form 1322, Aircraft Accident Autopsy Report	When used instead of SF 503 for reporting autopsies performed on aircraft accident fatalities.
SF 504, Clinical Record-History Parts I and II SF 505, Clinical Record-History Parts II&III SF 506, Clinical Record-Physical Examination SF 539 (or DD Form 2770), Medical Record-Abbreviated Medical Record SF 558, Medical Record-Emergency Care and Treatment *SF 507, Clinical Record Report On _ or Continuation of SF Report_____ *OF 275, Medical Record Report	When used instead of, or in addition to SF 504-506. When patient is admitted through the Emergency Room; Original. Always file as an attachment to the form to which it pertains. Do not separate from that form. When used in lieu of a SF, AF or DD form, file in place of that form.
SF 535, Clinical Record-Newborn SF 509, Medical Record-Progress Notes DD Form 2161, Referral for Civilian Medical Care SF 515, Medical Record-Tissues Examination	If an AFIP report is prepared, file it beneath the SF 515 to which it pertains
SF 516, Clinical Record-Operation Report OF 517, Medical Record-Anesthesia Recovery Room Record AF Form 1864, Perioperative Nursing Record OF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	Or locally approved form (check with State Requirements).

Form Number and Title	Instructions
<p>SF 533, - Medical Record – Prenatal and Pregnancy</p> <p>AF Form 3915, Labor and Delivery Flow Sheet AF Form 1302, Request and Consent for Sterilization AF Form 1225, Informed Consent for Blood Transfusion SF 523, Medical Record-Authorization for Autopsy OF 523B, Medical Record-Authorization for Tissue Donation SF 518, Medical Record-Blood or Blood Component SF 519B, Medical Record – Radiological Consultation Request Report OF 520, Medical Record-Electrocardiographic Record SF 546, Chemistry I SF 541, Medical Record-Gynecologic Cytology SF 547, Chemistry II SF 548, Chemistry III (urine) SF 549, Hematology</p> <p>SF 550, Urinalysis SF 551, Serology SF 552, Parasitology SF 553, Microbiology I SF 554, Microbiology II SF 555, Spinal Fluid SF 557, Miscellaneous (NOTE: Laboratory Reports may be computerized) DD Form 741, Eye Consultation AF Form 1412, Occupational Therapy Treatment Record AF Form 1535, Physical Therapy Consultation AF Form 1536, Physical Therapy Consultation Continuation Sheet Record SF 521, Medical Record-Dental SF 524, Medical Record-Radiation Therapy SF 525, Medical Record-Radiation Therapy Summary SF 526, Medical Record-Interstitial/Intercavitary Therapy SF 527, Medical Record-Group Muscle Strength, Joint R.O.M., Girth and Length Measurements SF 528, Medical Record-Muscle Function by Nerve Distribution: Face, Neck and Upper Extremity</p>	<p>Prenatal forms are filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and AF Form 3915.</p> <p>Facilities having Coulter Counter Model S, use AF Form 1976-Hematology instead of SF 549.</p>

Form Number and Title	Instructions
<p>SF 529, Medical Record-Muscle Function by Nerve Distribution: Trunk and Lower Extremity SF 530, Medical Record-Neurological Examination SF 531, Medical Record-Anatomical Figure AF Form 3066 (or 3066-1), Doctor's Orders AF Form 3069, Medication Administration Record AF 3068, PRN Medication Administration Record AF 3067, Intravenous Record AF Form 3241, Adult Admission Note AF Form 3242, Adult Patient Care Plan AF Form 3244, Pediatric Admission Note AF Form 3245, Pediatric Patient Care Plan AF Form 3247, Neonatal Admission Note AF Form 3248, Neonatal Patient Care Plan AF Form 3250, Obstetric Patient Care Plan AF Form 3252, Mental Health Patient Care Plan AF Form 3254, Patient Care Plan AF Form 3256, Patient/Family Teaching Flow Sheet AF Form 3257, ADL/Treatment Flow Sheet AF Form 3258, Generic Flow Sheet AF Form 3260, Discharge/Transport Summary SF 511, Medical Record-Vital Signs Record SF 512, Medical Record-Plotting Chart SF 512A, Medical Record-Plotting Chart-Blood Pressures DD Form 792, Twenty-Four Hour Patient Intake and Output Worksheet (if local requirements to file) Other prescribed nursing forms AF Form 570, Notification of Patient's Medical Status AF Form 1122, Personal Property Inventory AF Form 1122A, Personal Property Inventory (Continuation Sheet) Birth Certificate and Worksheet Death Certificate AF Form 438, Medical Care - Third Party Liability Notification Other command and local administrative forms Other release of information forms Correspondence Records received with transferred patients *DD Form 602, Patient Evacuation Tag</p>	<p>File beneath the SF 502 from the transferring MTF.</p>

A9.2. Forms and Identification. Inpatient records consist of the original copy of the forms listed in paragraph A9.1 above as applicable to the case. Each form filed in the inpatient record must contain, at a minimum: Patient name (last, first, middle), Register Number, patient's FMP, patient's and sponsor's SSN, MTF of treatment name and name of MTF where the outpatient records are maintained.

A9.3. Standard Forms Available on World Wide Web. Many Standard Forms are now available on the General Services Administration (GSA) website at <http://www.gsa.gov/forms/forms.htm>. These forms are in “pdf” format and must be downloaded with the adobe reader, available on the website. Forms not available on the website must be ordered from:

GSA-FSS

General Products Commodities Center

ATTN: 7FSM

819 Taylor Street

Fort Worth, TX 76102

A9.4. Electronically-Generated Forms (EF). The only forms package authorized for use is Jetform FormFlow. Word processing packages are directly forbidden because there is no method of locking the form so that it cannot be changed by the user. See AFI 37-160V8, *The Air Force Publications and Forms Management Program—Developing and Processing Forms*.

A9.4.1. The only exception to this policy is with forms for which the Interagency Committee on Medical Records (ICMR) has identified standard data elements. This is a work in progress, therefore standard data elements have not yet been identified for all Standard and Optional Forms. For those forms without identified standard elements, continue to follow the requirements in paragraph A9.4.

A9.4.1.1. For identified forms (See para A9.4.1.4), standard elements are required but mirror imaging is no longer required. Additional data elements that would change the meaning of the form cannot be added. Standard patient information is required on these forms.

A9.4.1.2. Patient information blocks on outpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), SSN/Identification Number, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, and Relationship to Sponsor. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of Medical Treatment Facility.

A9.4.1.3. Patient information blocks on inpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), SSN/Identification Number, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, Relationship to Sponsor, Register Number, and Ward Number. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of Medical Treatment Facility.

A9.4.1.4. To date, the forms for which standard data elements have been identified for the body of the form are: SF 509, SF 526, SF 558, SF 600, and OF 523B. Contact AFMOA/SGOI for a list of the identified standard data elements for these and any subsequent forms for which standard data elements have been identified.

A9.4.2. Optional Form (OF) 275, **Medical Record Report**, may be used in lieu of Standard forms, Air Force forms and DoD forms. OF 275, if used, must show the form number and title of the form being replaced. Information entered on the form must include all of the same information as the form it represents. File the OF 275 in the same location as the form it replaces. This form is not to be used for the creation of local forms.

A9.4.3. If a MTF desires to create a local form in lieu of a form which already exists, a waiver must be requested from the ICMR via AFMOA/SGOI, Brooks AFB, TX

A9.4.4. There are many forms for which an electronic form (EF) has been developed via an application entitled Perform Pro or Form Flow. As much as possible given application restraints, these EFs are mirror images of the current hard-copy form. The forms may be accessed through the Internet at <http://afpubs.hq.af.mil>.

A9.5. Overprinting of Forms. AFDPO/PPPF granted a waiver to AFI 37-160, V8 permitting overprinting on Standard Forms, as well as other forms listed in this attachment and the list of prescribed forms in the table of contents. The specific overprint must be approved by the local committee responsible for the medical record review function, recorded in the minutes of that committee, and approved by the MTF Commander. Overprints are authorized only when the material added does not conflict with the purpose for which the form was intended (Federal Property Management Regulation 101.11.804.1). Follow instructions in AFI 37-160, V8 concerning inclusion of the name of your organization followed by "overprint" in the lower right margin of the form; for example, 20th MDG Overprint. This waiver concerns overprinting only and does not grant authority to reprint existing Standard Forms at the local level.

A9.6. Problem Oriented Medical Record (POMR). If a MTF elects to use the POMR format, develop local directives to prescribe which cases will use this format, the method by which the forms are used and the manner in which the forms will be filed.

A9.7. Dictated and Transcribed Medical Forms. Include the dates and times of dictation and transcription, the clinical specialty or subspecialty of the health care provider preparing the report and their Air Force Specialty Code (AFSC) with the appropriate suffix on all transcribed reports, such as SFs 502, 504-506, 516, etc.

A9.8. Prenatal Records. File prenatal records of patients delivering in your MTF in the mother's inpatient delivery record. File the prenatal records in the outpatient record if the patient did not deliver in your MTF.

A9.9. Special Instructions Regarding Preparation of Certain Forms:

A9.9.1. AF Form 560 - Use this form as a work sheet for admitting the patient and for recording final diagnoses and procedures.

A9.9.1.1. Demographic information can be entered directly into the current automated system, without duplicate entry of the same information on AF Form 560. It is not necessary that the final automated coversheet be an exact copy of the AF Form 560.

A9.9.1.2. The appropriate health care provider completes AF Form 560 at discharge and authenticates the entry and identifies himself or herself by signature, initials or use of a name stamp.

A9.9.1.3. Upon receipt of the inpatient record, inpatient records personnel review the entire record to ensure completeness and accuracy of diagnostic and procedure information on the AF Form 560. If a question arises, consult the provider for clarification. The provider completing the form makes the final decision regarding additions and deletions of diagnoses and procedures.

A9.9.1.4. Sequence and code the diagnoses and procedures using the current version of the ICD. Prepare the final cover sheet (AF Form 565 or CHCS automated equivalent) after all information has been checked and completed.

A9.9.1.5. Complete an AF Form 560 for active duty military personnel hospitalized in a non-military medical treatment facility. A complete inpatient record is not necessary. When the patient is discharged to duty, complete the AF Form 560 with the diagnostic and procedure information obtained from the non-military medical treatment facility and file a copy in the member's outpatient record. If the patient is moved to the Air Force medical treatment facility, enter the fact and dates of treatment in item 40 of the current AF Form 560. Do not create a separate form; the entire period of treatment is covered with one AF Form 560.

A9.9.2. AF Form 565. Use this form or an CHCS automated equivalent as the final cover sheet of each record to provide an administrative and clinical summary of each admission. The appropriate health care provider will sign the provider's attestation statement on the final cover sheet. This statement is used to show that the provider agreed with the identification of the principal diagnosis and procedure, any comorbidities or complications, and the sequencing of the diagnoses and procedures.

A9.9.2.1. A locally designated health care provider will sign the AF Form 565, in an administrative capacity only, for a military member hospitalized in a nonfederal hospital. (The current automated system requires the name of a health care provider in order for the record to be entered.) At local MTF option, in addition to the provider's signature, a stamp indicating that the record was created for administrative purposes only may also be used.

A9.9.2.2. Use AF Form 565 in death cases for persons who are inpatients at the time of death.

A9.9.3. Disposition AF Forms 565, AF Form 560 and SF 502 as follows:

A9.9.3.1. Insert the original AF Form 565 and SF 502 in the inpatient record. File the worksheet AF Form 560 behind the original AF Form 565.

A9.9.3.2. For an active duty patient pending final disposition of Permanent Change of Station (PCS) to home or transfer to a VA hospital, place all additional copies of these forms in a suspense file. Keep the patient in a change-of-status category until final disposition of the case. Upon disposition, patient administration personnel complete the administrative data on the final cover sheet (i.e., regarding type of disposition, etc.).

A9.9.3.3. For all other patients, insert a copy of AF Form 565 or AF Form 560 (when used in lieu of AF Form 565) and the SF 502, when prepared, in the outpatient record after final disposition of the case.

A9.9.3.4. File a copy of the AF Form 565 and SF 502 in the outpatient record of patients being transferred to another facility.

A9.9.4. Prenatal documentation is maintained in the OB/GYN clinic until the mother delivers in your MTF.

A9.9.4.1. After delivery, maintain the documents with the other inpatient documentation.

A9.9.4.2. If the delivery was not performed in your MTF, file the prenatal package (as a whole package with prenatal treatment documents filed chronologically between the SF 533 and AF Form 3915 in the outpatient record.

A9.9.5. Self-Determination Act (Advance Directive) Documents. When provided by the patient (at each admission), the documents (which may include the living will, durable power of attorney and organ donation paperwork) will be filed with the other administrative documents in the record. After discharge, the patient may take the documents home with them and bring them back if admitted again at some future date.

A9.9.6. Completing the reverse of AF Forms 3068 and 3069.

A9.9.6.1. The reverse of these forms contain a section for the initials and signatures of nursing staff administering the medications. Instead of signing the reverse of these forms, utilize a separate sheet which contains the names, signatures and initials of the nursing staff.

A9.9.6.2. When there is a separate sheet with the names, signatures and initials, the nursing staff is only required to initial the reverse of the AF Form 3068 and 3069 when administering medications.

A9.9.6.3. File the sheet after the AF Form 3068 or 3069.

Attachment 10

PROCEDURES RELATING TO DECEASED PATIENTS

A10.1. Processing Imminent Death Cases. Reference the PEBLO (Physical Evaluation Board Liaison Officer) for procedures on processing of imminent death cases.

A10.2. Responsibility for Preparing Death Cases:

A10.2.1. Death of a person while being attended outside the MTF – the attending Air Force medical officer.

A10.2.2. Death of a person in an Air Force-owned or leased aircraft – the medical treatment unit serving the base which investigated the accident.

A10.2.3. Death of other Air Force personnel who are not patients in a MTF at time of death – the medical treatment unit serving the base which investigated the circumstances of death.

A10.2.4. Death of a nonmilitary person on an Air Force base – the medical treatment unit serving the base.

A10.2.5. Death of a person being staged through an aeromedical staging flight (ASF) – the medical treatment unit supporting the ASF.

A10.2.6. Death of a person while in transit in an inpatient status – the medical facility receiving the remains. **NOTE:** Treat as transfer-in patients those who die while in transit (either while in flight or in an ambulance between facilities) or while being staged through an ASF.

A10.3. Policies Regarding Deaths.

A10.3.1. See AFI 34-501, *Mortuary Affairs Program*, for instructions on preparing, inspecting and shipping remains and completing related forms and reports. **NOTE:** DoD policy requires that when a military member or family member dies outside the U.S., the death must be officially recorded with the local civil authorities.

A10.3.2. A health care provider verifies all deaths occurring at an Air Force medical treatment facility and on an Air Force installation.

A10.3.3. Do not remove the body without permission of civil authorities when a member of the Armed Forces on active duty dies outside the limits of an Air Force installation. See A10.3.4 for further guidance on the responsibility for moving remains.

A10.3.3.1. The commander consults local civil authorities to develop procedures to follow when Armed Forces personnel die within or beyond installation limits.

A10.3.3.2. Obtain a transient or burial permit from the proper civil authority before removing a body from an Air Force base for shipment or burial.

A10.3.3.3. Release remains to mortuary personnel within 24 hours after death unless extenuating circumstances exist. Ensure that the death certificate is completed and signed by the responsible medical officer before releasing the remains. The mortuary representative (military or civilian) taking custody of the remains signs a receipt for the remains. File the receipt in the deceased's inpatient or outpatient record, as appropriate.

A10.3.4. Initial movement of remains is accomplished as follows:

A10.3.4.1. As authorized by the base commander, in deaths occurring on the military installation, the MTF provides transportation of the deceased person from the site of death (or presumed death) to the MTF. A provider pronounces death at the site or the MTF, prepares a death certificate and makes a decision regarding an autopsy. The autopsy is performed if indicated or required (See A10.4.). Release the remains to mortuary services for final disposition.

A10.3.4.2. Local civil authorities exercise control over the movement of remains in the event of an off-installation death. Once the remains are released, determine if an autopsy will be performed (see A10.4.). If affirmative, medical personnel transport the remains to the MTF. If negative, mortuary services transports the remains to the contract funeral home or government mortuary. **NOTE:** In the event of a military aircraft accident, a postmortem (autopsy) is usually indicated.

A10.3.4.3. In a disaster or multiple death situation everyone available assists in any way possible. The mortuary officer calls the motor pool for transportation to move the remains during search and recovery operations. Remains are placed in body bags for movement.

A10.3.5. When a patient dies, notify the Casualty Affairs Liaison (CAL) or their representative immediately.

A10.3.6. Collect and inventory all personal property of the deceased as soon as possible following the death of a military or civilian patient. Send personal effects of a military patient to the summary court officer. Send personal effects of civilians to an executor or administrator, or (if none appointed) to the nearest NOK. The executor, administrator or nearest NOK, as appropriate, signs the inventory as a receipt for effects. File the receipt in the patient's inpatient or outpatient record, as appropriate.

A10.3.7. Certificate of Death. The provider pronouncing death prepares a death certificate and sends it to the proper authorities according to state and civil requirements. File one copy of the certificate in the deceased patient's inpatient record. In overseas areas, prepare DD Form 2064, **Certificate of Death (Overseas)**, per AFI 34-501.

A10.3.8. Reporting Deaths. The hospital commander reports deaths as required by AFI 36-3002 when a person dies at an Air Force medical treatment facility or en route to the MTF. Establish local procedures regarding other required notifications.

A10.3.9. Reporting Stillbirths. Prepare a certificate of death and file it as required by state and civil law. File one copy of the fetal death certificate with the mother's inpatient record. Handle remains as for other deaths (as far as is appropriate). In the case of an abortion, send the surgical specimen to the laboratory the same as for other surgical specimens. **NOTE:** Even when not required by state or civil law, a fetal death certificate may be issued if the NOK requests the coroner or medical examiner to do so.

A10.3.10. Comply with AFI 34-501, when deceased Armed Forces personnel cannot be identified by local means. Utilize the resources of the Office of Air Force Medical Examiner (OAFME) to the maximum extent possible to support the identification of remains.

A10.4. Performing Post Mortem (Autopsy).

A10.4.1. File the authorization to perform a post mortem examination in the deceased's inpatient or outpatient record, as appropriate. Perform a post mortem only with the consent of the surviving

spouse, NOK, person having right of burial, as specified in DoD Directive 6465.2, or at the request of the local coroner or medical examiner except in the circumstances described in A10.4.4.

A10.4.2. Under normal conditions, complete the post mortem within 24 hours after the remains are received, appropriate records are available and authorization has been granted.

A10.4.3. Record the post mortem on SF 503, **Medical Record-Autopsy Protocol**. (Except those performed under AFI 91-204, *Safety Investigations and Reports*.) File the original copy with the health records of the deceased. Maintain a completed copy in the clinical laboratory.

A10.4.4. Post Mortems on Members of Armed Forces. Perform a complete post mortem when a member of the Armed Forces (called or ordered into active military service for a period of more than 90 days) dies on an Air Force base if any of the following applies:

A10.4.4.1. Death occurred under circumstances suggesting crime, suicide, or other appearances requiring investigation. Do not exclude a post mortem merely because a superficial examination may suggest a conclusion as to cause of death.

A10.4.4.2. Cause of death might constitute a menace to public health.

A10.4.4.3. Cause of (traumatic) death is other than result of a military accident, but physiological or pathological changes may have precipitated the events leading to death and cannot be determined without a post mortem.

A10.4.4.4. Death occurred while the person was serving as an aircrew member in a military aircraft. **NOTE:** AFI 91-204, specifies that an autopsy should be performed when practicable regardless of location of crash or incident.

A10.4.4.5. Physician is unable to establish the cause of death.

A10.4.4.6. Death occurred while the person was confined in disciplinary custody but had not been punitively discharged from the military service.

A10.4.4.7. The commanding officer of an installation or command, the investigating officer, other fact-finding body or medical examiner requires the post mortem to determine the cause and manner of death (such as sudden, unexpected death, homicide or suicide); to secure information for completion of military records; to protect the welfare of the military community; or when the service member is an aircrew member and the death occurs during flight operations.

A10.4.5. Authorization for Post Mortem on U.S. Armed Forces Personnel. The installation commander or AFME is the approving authority for the post mortem examinations in A10.4.4. in areas of exclusive Federal jurisdiction and in other areas when the civil authority has released jurisdiction to the Military Services. In areas outside the U.S. and its territories, existing Status of Forces Agreements apply. When the host government relinquishes its authority, the AFME or installation commander authorizes the post mortem. This approving authority may be delegated to the MTF Commander, but must be written and always current.

A10.4.6. Performing a Post Mortem on a Civilian. Abide by the laws of the state or foreign nation where the Air Force installation is located when performing a post mortem for a deceased civilian.

A10.4.6.1. Obtain the written, signed permission of the nearest NOK, or an order by an appropriate civil authority if the death occurred in unusual or suspicious circumstances. Develop proce-

dures incorporating the requirements of this instruction, relevant laws, existing legal agreements and other legitimate requirements of local authorities.

A10.4.6.2. For post mortem purposes, treat as civilians the remains of members of the National Guard, Reserve Officers Training Corps and other reserve components not on active duty for training.

A10.4.6.3. When consent of NOK is required, check to verify notification and obtain the required consent on SF 523, **Medical Record-Authorization for Autopsy**.

A10.4.6.4. After deliverance of casualty notice to the family or NOK and confirmation of its receipt, the MTF Commander sends a condolence letter to the family or NOK and requests permission for a post mortem. The consent is filed in the patient's inpatient or outpatient record, as appropriate.

A10.4.6.5. At overseas installations, request the family or NOK send the reply to request for post mortem consent to AFMOA/SGOC, Bolling AFB DC 20332-7050. Upon receipt of reply, AFMOA/SGOC will send a priority wire through military message channels advising of the decision and then send the original message by mail to the MTF for filing in the patient's inpatient or outpatient record, as appropriate.

A10.4.7. Performing a Post Mortem on Foreign Military Personnel. Use the procedures outlined in A10.4.4. for deceased foreign military personnel who were in active military service in the CONUS. Obtain permission for post mortem from the military attache of the foreign embassy. Include this request for permission in the casualty report required by AFI 36-3002.

A10.4.8. Organ Disposal After Post Mortem. Return all organs and tissues removed during post mortem to the body, except those organs, tissues and tissue fluids essential to diagnose the cause of death or intended for studies authorized by the family or NOK or required by law (see DoD Directive 6465.2). Dispose of, in a humane and dignified manner, any organs or tissues retained after release of remains to mortuary officials.

A10.5. Disposition of Outpatient Records on Deceased Active Duty Personnel. See AFI 36-2608 and AFI 36-3002 for guidance on the disposition of the outpatient record when an active duty member of the U.S. Armed Services expires.

Attachment 11

INPATIENT RECORDS ADMINISTRATION

A11.1. Creating Inpatient Records.

A11.1.1. Prepare an inpatient record for:

A11.1.1.1. Patients admitted to an inpatient unit of an Air Force facility, including patients admitted and discharged before 2400 hours on the day of admission regardless of the type of discharge. See [chapter 5](#), paragraph 5.12 for instructions on readmission of patients.

A11.1.1.2. Active duty personnel admitted to non-Federal hospitals and others for whom records responsibility is assumed.

A11.1.1.3. Live births occurring in Air Force medical treatment facilities. **NOTE:** Do not create a separate record on stillbirths.

A11.1.1.4. Patients who die in transit. The MTF receiving the remains processes the records and completes the AF Form 565 as if the patient had transferred in.

A11.1.1.5. All patients admitted to a tactical medical facility during deployment (including fixed contingency facilities). See [chapter 2](#) for instructions.

A11.1.2. A “canceled admission” may be appropriate in some instances. Annotate the admission work sheet with the reason for cancellation and place a copy in the patient’s outpatient record. File all other paperwork generated by the admission (e.g., History and Physical, progress notes, laboratory and x-ray reports, etc.) in the patient’s inpatient record folder. Separate this paperwork from previous and subsequent admissions. Do not code the record as an inpatient record. Record the episode as an outpatient visit.

A11.2. Ambulatory Procedure Visit (APV) and Observation Case Records. File the documents from APV episodes and observation cases in E.A.R. folders. See [chapter 4](#) for guidelines on creation and maintenance of the EAR folder and on APV and observation records.

A11.3. Emergency Room Deaths (ERD) and Dead-on-Arrival (DOA) Cases (Previously entered as Carded For Record Only (CRO) admissions). Code these records in the current ambulatory system. Maintain the documentation in E.A.R. folders. See [chapter 4](#), para 4.5 for guidelines on creation and maintenance of the E.A.R. folder and on ERD and DOA records.

A11.4. Creation of the Master Patient Index (MPI): The MPI serves as an alphabetical index of all hospital patients and patients for whom administrative responsibility is assumed (e.g., active duty military in non-federal medical treatment facilities).

A11.4.1. This MPI is created by and stored in the current automated system.

A11.4.2. MTFs without automation will maintain either hard-copy index cards or readily accessible and properly maintained DD Forms 739 as they are a source for locating prior admission data.

A11.5. Preparing and Filing Inpatient Record Folders.

A11.5.1. Number folders according to the social security number (SSN) as follows:

If the patient is:	Use SSN of:
Active Duty/ARC	Member
Family Member	Sponsor
Civilian Employee	Employee
Retired military	Member
Civilian Emergency	Patient
Foreign national, allied or neutral military member without SSN	Construct a pseudo SSN (See paragraph A3.1.2)

A11.5.2. See paragraph A3.1.2 for guidance on constructing a pseudo SSN whenever the actual SSN cannot be determined

A11.5.3. Select an AF Form in the 788A-788J series, as appropriate, according to the last two digits of the applicable SSN. Enter patient identification information on the front of the folder. (See attachment 3 for guidelines.) Documents placed in the folder may be held together with a 3-inch fastener or fastened into the folder. When records are retired to the NPRC, documents are permanently affixed to the folder.

A11.5.4. File records in terminal digit format by SSN. If desired, small MTFs may file the records alphabetically by patient's last name.

A11.5.5. If a patient is readmitted, the previous record is brought forward and filed, as a separate entity, in the folder of the current admission record.

A11.5.6. Authorized personnel at the MTF may access inpatient records upon request. Substitute an AF Form 614 for the inpatient record when removed from the file.

A11.6. Standards for Inpatient Records.

A11.6.1. Develop and maintain inpatient records using guidelines in this attachment, attachment 9, and the JCAHO standards.

A11.6.2. Air Force Medical Operations Agency, Patient Administration Division (AFMOA/SGOI) grants authority to set up or close down an inpatient record library.

A11.6.3. Establish a medical record review function. Review records to ensure quality, clinical pertinence, information assurance, timely completion of records, and that records are prepared and kept according to Air Force directives and JCAHO standards. A representative sample of every provider's records is examined.

A11.7. Contents of Inpatient Records. See [attachment 9](#) for arrangement of forms in the inpatient record and for additional instructions regarding specific forms.

A11.7.1. Maintain inpatient records received with a transfer-in patient as a component part of, and attached to, the current inpatient record. Do not break up the transfer record and interfile its forms among the forms of the current record. **NOTE:** If the original record was sent, copy and maintain the pertinent portions, returning the original record to the transferring MTF.

A11.7.2. SF 502.

A11.7.2.1. The health care provider dictates a concise clinical resume (narrative summary) which is transcribed on the SF 502 for:

A11.7.2.1.1. Patients hospitalized 8 days or more.

A11.7.2.1.2. Patients received by transfer for further medical treatment regardless of the length of stay.

A11.7.2.1.3. Patients who die after admission.

A11.7.2.2. The narrative summary may be dictated or handwritten on the SF 502 if the patient has been hospitalized less than 8 days.

A11.7.2.3. When a patient is transferred to another MTF for further medical care, a handwritten summary will be completed. If, for expediency's sake, a quick transfer note is written, a written or dictated summary will follow.

A11.7.2.4. Final progress notes on SF 509 may be substituted for narrative summaries on patients with minor problems requiring less than a 48-hour stay, normal newborn infants or uncomplicated obstetrical deliveries. Include any instructions given to the patient or family in the final progress note. Insert a copy in the patient's outpatient record.

A11.7.2.5. Transcribe a dictated narrative summary within seven workdays after patient discharge. Annotate the date and time of dictation and transcription on the SF 502.

A11.7.2.6. Forwarding SF 502:

A11.7.2.6.1. File a copy in the patient's outpatient record.

A11.7.2.6.2. Send a copy to the attending health care provider of each referring MTF upon discharge. Ensure a copy is also sent to the outpatient records section of these same MTFs.

A11.7.2.6.3. Send one copy to the Commandant (G-KMA), U.S. Coast Guard, Washington DC 20590, when U.S. Coast Guard members on active duty are discharged.

A11.7.2.7. Upon disposition of a uniformed services member who is already on the Temporary Disability Retirement List (TDRL) when admitted, send a copy of the AF Form 565 and SF 502 to the parent service as indicated below:

Air Force:

HQ AFPC/DPAMM

550 C Street West, Suite 26

Randolph AFB TX 78150-4728

Navy:

Department of the Navy

Bureau of Medicine and Surgery (MED-25)

2300 E St., NW

Washington DC 20372-5300

Public Health Service and National Oceanic Atmospheric Administration:

Medical Affairs Branch

ATTN: Dr. David Hooper

Department of Health and Human Services

5600 Fishers Lane, Rm 4C-06

Rockville, MD 20857

A11.7.3. SF 504, SF 505, and SF 506.

A11.7.3.1. Health care providers complete the history and physical examination records within 24 hours after admission. Completion of any part of the history or physical examination by a medical student/physician's assistant (PA) student does not relieve the attending health care provider of the responsibility to ensure that an adequate history and physical examination is performed and documented. (See AFI 44-102 for procedures concerning histories and physicals conducted by medical/PA students.) The certified nurse midwife completes the history and physical examination on obstetrical patients for whom he/she is responsible. A properly credentialed oral surgeon completes the physical examination for patients admitted for dental services. Podiatrists complete the history and physical as applicable to the podiatry problem.

A11.7.3.2. If an adequate history and physical examination is sent with transfer-in patients, the provider may document an interval note on SF 509 stating no changes. The provider will document any important changes.

A11.7.3.3. Enter a note in the SF 509 referring to the previous history and physical examination for patients readmitted within one month to the same MTF for the same condition. Document any changes. If desired, place a copy of the previous history and physical in the current record.

A11.7.3.4. If a history and physical examination was performed within 30 days before admission, such as in the physician's office, place a durable, legible copy in the inpatient record and document any changes in the SF 509.

A11.7.4. DD Form 2770, **Abbreviated Medical Record**, may be used for the following:

A11.7.4.1. Hospitalizations of five days or less for minor medical conditions normally treated on an ambulatory basis when care in the patient's residence is inadequate.

A11.7.4.2. Hospitalizations of two days or less for minor surgical procedures performed under local or peripheral nerve block anesthesia. This includes stable anesthesia Class III or IV with minor procedure under local or regional anesthesia with or without IV sedation.

A11.7.4.3. Hospitalizations of five days or less for delivering obstetric patients whose intrapartum and postpartum course is uncomplicated, provided that a complete prenatal record is included in the inpatient record.

A11.7.4.4. Hospitalizations of 48 hours or less for surgeries when the patient is clearly anesthesia Class I or II, regardless of type of anesthesia used.

A11.7.5. SF 535. Prepare SF 535 in duplicate for all newborn infants. Include the original in the newborn's inpatient record. File a copy in the newborn's outpatient record.

A11.7.6. SF 509. Record the patient's diagnosis, treatment and care on the SF 509 to chronologically describe the clinical course of the patient.

A11.7.6.1. Determine the frequency of the notes based on the patient's condition. Make daily notations for the following: the first five days after a patient has undergone a major operation; if the patient is seriously ill.

A11.7.6.2. Record the postoperative note on the SF 509. The form may be overprinted locally to provide a format.

A11.7.6.3. Document the informed consent on the SF 509. See AFI 44-102 for instructions.

A11.7.7. SF 516. Report surgical operations, including those performed in the ambulatory surgery unit, on SF 516. Dictate the report immediately following surgery. Annotate the date and time of dictation and transcription on the form. Include in the report a description of the findings, the technique used, the tissue removed or altered, the postoperative diagnosis and the condition of the patient at the end of the operation. Complete all applicable items in the top portion of the SF 516.

A11.7.8. Laboratory and Radiology reports. When a computerized or automated summary of all laboratory and radiology report results compiled during the patient's hospitalization is provided, file only the cumulative final report. Destroy all previous computerized/automated report results.

A11.7.9. AF Form 3066 (or 3066-1). A provider writes and signs orders on the AF Form 3066 (or 3066-1) or enters the information into the current automated system.

A11.7.9.1. When a hardcopy AF Form 3066 (or 3066-1) is utilized, maintain the original with the patient's inpatient record. When medications are ordered, send a copy to the Pharmacy. The provider's SSN is only required in the provider's stamp on the Pharmacy copy of prescription for controlled substances (See AFI 44-102). This SSN will not appear anywhere in the patient's record.

A11.7.9.2. A verbal or telephone order may be given to a registered nurse. In such cases, the provider confirms the order and signs it within 24 hours.

A11.8. Disposition of Inpatient Records.

A11.8.1. When transferring patients to another MTF, send a complete and legible copy of the current inpatient record, original outpatient record, and copies of any previous admissions pertinent to the patient's current condition. If complete and legible copies cannot be made in time for the patient's transfer, send the original current inpatient record. **NOTE:** The receiving MTF returns original records to the transferring MTF when they have served their purpose. Also, send any x-ray films and duplicate slides or surgical specimens when the findings have a direct bearing on the diagnosis and treatment.

A11.8.2. The admitting facility notifies the originating MTF of patients admitted while on directed convalescence, PCS home, or AWOL from another medical facility while in patient status. If the patient will remain at the new MTF, the initial facility transfers the individual to the new MTF and forwards the patient's records.

A11.8.3. When transferring patients to nonmilitary medical treatment facilities, a transcript or copy of pertinent pages may accompany the patient. Never release the original records; however, pertinent x-ray films are furnished to the receiving nonmilitary medical treatment facility as required.

A11.8.4. Send a copy of the current inpatient record and any x-ray films when a military patient still on active duty is transferred to a VA hospital pending separation or retirement from the uniformed services.

A11.8.5. Original records of NATO (National Atlantic Treaty Organization) military personnel and their family members (including x-ray film and medical examination reports) are sent in a sealed envelope with the individual concerned upon transfer to another MTF. When the individual is discharged, return the record to the parent country. (See AFMAN 37-139, Table 41-11, Rule 13.) Retain copies of pertinent records necessary for quality assurance review.

A11.8.6. Inpatient records of other than NATO military personnel and their family members are handled the same as any other inpatient record.

A11.8.7. Patients discharged without definitive diagnosis. The inpatient records section maintains, in a suspense file, records which the provider has indicated should be held pending pathology reports, laboratory test results, or other confirmations. Never maintain the records in suspense longer than one month after the month of disposition. Process the record with whatever information is available. The record may be corrected at a later date if information which alters the final diagnosis is received.

A11.8.8. See [chapter 2](#), para 2.11.5 for instructions on retirement of inpatient records to the NPRC.

A11.9. Fetal Monitor Strip Filing Procedures. Maintain the fetal monitor strips on the obstetrical unit with the prenatal record until delivery.

A11.9.1. Identify and file strips in envelopes which can be filed efficiently in the standard fiberboard boxes used to retire records. (See AFI 37-138.) NOTE: Digitized, or other format, fetal monitor strips which can be printed out are filed in the infant's inpatient record or the mother's if the infant is stillborn.

A11.9.2. After discharge of the infant, send the fetal monitor strips to the inpatient record section for maintenance until retirement to the NPRC. Annotate the envelope with the name and register number of the infant, sponsor's name and SSN, name of the MTF, and date of infant's birth.

A11.9.3. When an undelivered patient is transferred, send all fetal monitoring strips prepared with the copy of inpatient records to the receiving MTF.

A11.9.4. Send the fetal monitoring strips with the patient, when a newborn is transferred to another MTF during initial hospitalization.

A11.9.5. File fetal monitoring strips for stillborn infants under the register number of the mother.

A11.9.6. When it cannot be determined that prenatal care terminated in hospitalization or delivery, send the outpatient fetal monitoring strips to the inpatient record section. File these strips and retire to the NPRC.

A11.9.7. Retire fetal monitoring strips to the NPRC in accordance with AFMAN 37-139, Table 41-11, Rules 21 and 21.01. The annual cutoff for fetal monitoring strips is the end of the year in which birth occurred. Fetal monitoring strips are maintained for one year after cutoff and then retired. Those strips which are printed and filed in the record are retired with the record.

A11.10. Managing the Medical Transcription Center.

A11.10.1. Medical transcription centers provide timely and accurate transcription of dictation dealing with patient care. Resources may be used to type other medical staff material only after all dictated patient care reports have been transcribed. The inpatient records department normally manages the medical transcription center. Monitor the quality of all medical transcription.

A11.10.2. The production goals for medical transcribers will be determined within individual work settings. Take into account the following variables when determining accurate productivity.

A11.10.2.1. INPUT:

- A11.10.2.1.1. Dictator characteristics (i.e., articulation, English as first or second language)
- A11.10.2.1.2. Dictation equipment characteristics (e.g., analog, digital, media quality)
- A11.10.2.1.3. Type of report (e.g., narrative summary, operative report, progress notes, etc.)
- A11.10.2.1.4. Completeness of dictation (i.e., does transcriber have to stop and look up information)
- A11.10.2.1.5. Difficulty factors of report (e.g., new drugs, diseases, procedures or instruments)
- A11.10.2.1.6. Environmental factors (i.e., background noise, sound quality)

A11.10.2.2. OUTPUT:

- A11.10.2.2.1. Knowledge of medical transcriptionist (i.e., education, experience, language fluency)
- A11.10.2.2.2. Medical transcriptionist equipment awareness
- A11.10.2.2.3. Transcription equipment characteristics (e.g., quality, features, maintenance)
- A11.10.2.2.4. Resource availability (i.e., current references)
- A11.10.2.2.5. Environmental factors (e.g., ergonomics, distractions)
- A11.10.2.2.6. Performance expectations (i.e., demands for quality and quantity, personnel expectations)
- A11.10.2.2.7. Other responsibilities (e.g., answering telephones, filing, assisting others)

A11.10.3. Productivity goals should be analyzed periodically, especially when any of the variables listed in A11.10.2 change.

A11.10.4. If the transcription functionality is provided by contract services, ensure the following:

- A11.10.4.1. There will be a quality manager to ensure transcription requirements are met and that the products are monitored for quality.
- A11.10.4.2. The contract will be written requiring compliance with all of the HIPAA security and privacy rules.

Attachment 12

DEFINITION OF A REPORTABLE VISIT

A12.1. Visit Criteria. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen is classified as a visit. The following criteria must be met before a visit can be counted:

A12.1.1. Interaction Required. There must be interaction between a patient and a healthcare provider.

A12.1.2. Independent Judgment, Assessment, and Action. Independent judgment about the patient's care must be used. Assessment of the patient's condition must be made and one or more of the following must be accomplished:

A12.1.2.1. Examination

A12.1.2.2. Diagnosis

A12.1.2.3. Counseling

A12.1.2.4. Treatment

A12.1.3. Medical Records Documentation. Documentation must be made in the patient's authorized record of medical treatment. Documentation must include at least the date, name of clinic and facility, reason for visit, assessment of the patient, description of the interaction between the patient and the healthcare provider, disposition, and signature of the provider of care. (Repetitive clinic visits to the specialty clinics, i.e., physical therapy and occupational therapy, will not require full documentation as stated above after an initial visit unless there is a change in the prescribed treatment. There must also be final documentation upon completion of prescribed treatment.) The documentation may be maintained in paper or electronic media, or a combination of both. In all instances, a clear and acceptable audit trail must be maintained.

A12.1.4. The source system for classifying an encounter as a "visit" or an "occasion of service" is the Patient Appointment and Scheduling (PAS) subsystem of the Composite Health Care System (CHCS), specifically, the clinic and workload type data fields of the Clinic Profile and Appointment Type files, respectively. If the Clinic Type field indicates "no-count" then any encounters in that clinic will be an "occasion of service". If an appointment is scheduled or walked-in using an appointment type for which the Workload Type data field is designated as "no-count", the associated encounter will be an "occasion of service". These files and fields are user-defined and maintained at the MTF.

A12.1.5. Classification. Classification of a visit shall not be dependent on the following items.

A12.1.5.1. Physical location of the patient.

A12.1.5.2. Technique or method of providing health care service (such as telephonic, telemedicine, or direct patient contact), when the criteria in A12.1 above are met.

A12.2. Types of Visits. The following types of visits are reportable **when the criteria in A12.1 above are met.**

A12.2.1. Ambulatory Visits. A visit occurs in the following situations:

A12.2.1.1. Each time an inpatient is seen in an outpatient clinic within the admitting MTF on a consultative basis (inpatient visit).

A12.2.1.2. Each time a clinic service provider from other than the attending clinic service, provides consultation/treatments to an inpatient on a ward or hospital unit (inpatient visit).

A12.2.1.3. All encounters with patients who have not been admitted to the reporting MTF as an inpatient (outpatient visit).

A12.2.1.4. Each time medical advice or consultation is provided by a privileged provider to the patient by telephone (outpatient visit).

A12.2.1.5. Each time a patient's treatment/evaluation results in an admission and is not part of the pre-admission or admission process (outpatient visit).

A12.2.1.6. Each time all or part of a complete examination or flight physical examination, regardless of the type, is performed in a clinic or specialty service. Under this rule, a complete physical examination requiring the patient to be examined or evaluated in four different clinics is reported as a visit in each of the four clinics. For handling of other types of examinations, see A12.3 (outpatient visit).

A12.2.2. Multiple Visits.

A12.2.2.1. Multiclinic Visits. Multiple visit occur if a patient is provided care in different clinics or is referred from one care provider to another care provider for consultation and the second provider meets the criteria in A12.1. For example, a patient seen at the primary care clinic and at two other specialty clinics on the same day can have three visits; or, a patient visiting a clinic in the morning and again in the afternoon can be reported as two visits. However, to accrue the two visits, the first visit must be completed. For example, the patient must have been evaluated, treated, and dispositioned, and the required documentation made in the medical records. Only one visit occurs if the visit in the afternoon is merely a continuation of the visit in the morning. For example, a patient seen in the orthopedic clinic in the morning is sent to radiology for x-rays and returns to the orthopedic clinic in the afternoon for continued evaluation or treatment. These rules apply even if the patient is admitted to an inpatient status immediately following the clinic visit.

A12.2.2.2. Multiprovider Visits. When a patient is seen by more than one healthcare provider of the same specialty for the same problem during the same encounter, only one visit occurs per patient. An exception to this rule involves Telemedicine (see A12.2.2.4) If the patient requests a second opinion, an additional visit occurs provided the criteria in A12.1 are met.

A12.2.2.3. Multispecialty Clinic. When providers from two or more different specialties function as a team (e.g., red team, green team, etc.) providing an integrated approach to healthcare to support managed care.

A12.2.2.3.1. Each provider on the team may accrue a visit if they independently meet the criteria in A12.1 during their interaction with the patient.

A12.2.2.3.2. Visits occur if patient care is provided in multispecialty clinics if the criteria in A12.1 are met. Currently, multispecialty clinics are designated as green team, red team, and etc. clinics, usually identified as Primary Care or Family Practice clinics. In order to generate the proper MEPRS code on the ADS Encounter Form, the clerk appointing the patient should enter the MEPRS code corresponding to the specialty of the provider in the appointment file

by overriding the MEPRS field on the screen in the Managed Care Program (MCP) or PAS module in CHCS. This action will ensure that the correct MEPRS code is reflected in CHCS and ADS, and will be transmitted to the Standard Ambulatory Data Record (SADR). If the MEPRS code of the multispecialty clinic is entered in the appointment file in CHCS, the multispecialty clinic MEPRS code will appear on the ADS Encounter Form and will be transmitted on the SADR. If manual intervention is performed during end-of-day processing to change the MEPRS code to that of the provider specialty, the change will affect any CHCS outputs, but will not change the MEPRS code in ADS on the SADR. Thus, the process of manual intervention does not completely address the problem of incorrect MEPRS code assignments and contributes to discrepancies between ADS and CHCS.

A12.2.2.3.3. Multiple visits may occur if patient care is provided in multispecialty clinics by two or more providers with different specialties. In instances where the initial provider requests a consultation within a teamed provider of another specialty, two visits occur, as long as the services of the consulting provider fulfill the criteria for a visit. Using the current system, the second provider's ADS Encounter Form must reflect the provider's specialty MEPRS code. In all cases, a second ADS Encounter Form using a walk-in appointment type through CHCS and ADS must be generated. If this form reflects the Primary Care or Family Practice MEPRS code, manual intervention will be required to change the MEPRS clinic code to the specialty of the second provider.

A12.2.2.4. Telemedicine Visits. If a patient is present in a provider's office and another provider is contacted through telemedicine, both providers may accrue a visit in their clinic specialty. This is considered a valid medical consultation, and as such, it requires proper medical documentation by the consulted physician, ensuring that the criteria for a visit are met.

A12.3. Services Not Reportable as Visits

A12.3.1. Occasion of Service. Without an assessment of the patient's condition or the exercise of independent judgment as to the patient's care, screening examinations, procedures, or tests are classified as an "occasion of service" because they do not meet the criteria in A12.1. Examples of "occasions of service" include blood pressure measurements, weight measurements, an advice nurse functioning under a written protocol, and prescription renewals that do not involve direct interaction between the patient and the privileged provider.

A12.3.2. Ward Rounds/Grand Rounds. Ward rounds and grand rounds are considered part of the inpatient care regimen and are not visits. Encounters for an inpatient to an outpatient clinic for the convenience of the provider, instead of ward or grand rounds, are not visits.

A12.3.3. Group Education and Information Sessions. Group education and information sessions that do not meet the criteria in A12.1 are not visits.

Attachment 13**VALIDATION OF REPORTED WORKLOAD**

A13.1. Verification/Audit. Each medical treatment facility must have an easily auditable workload collection and reporting system.

A13.1.1. There are several levels at which the workload needs to be verified/audited:

A13.1.1.1. All visits accounted for in CHCS have adequate documentation in appropriate patient's outpatient record or other accepted form.

A13.1.1.2. All "kept" appointments in CHCS are accounted for with an ADS "bubble sheet" or manually coded into the ADS server.

A13.1.1.3. Documentation in the outpatient record supports the ICD/CPT codes appearing in ADS.

A13.2. Audit Sample Requirements. A normal audit sample should represent a statistically significant number, and will be at least one day's patient visits per month from each separately organized specialty clinic or ancillary service for which visits are reported.

A13.2.1. Reporting should be verified from each clinic on a monthly basis, except as follows:

A13.2.1.1. If a clinic has no errors in three consecutive months, the verification may be reduced to once every three months. When errors are found, verification will again be done once a month.

A13.2.1.2. When a clinic's error rate exceeds ten percent per month for three consecutive months, the clinic's data will be verified on a weekly basis until the error rate has been reduced to less than ten percent for at least two consecutive weeks. At that time the clinic's data will again be verified on a monthly basis.

A13.3. Monitoring Requirements. Deviations that result in the need for weekly monitoring must be reported to the Operations Squadron Commander and the Chief, Hospital/Clinic Services.

A13.4. Documentation. Verification/Audit will be documented to include date performed, number of records reviewed, and findings. Because of variations in facility size, health care providers assigned and appointment scheduling techniques, etc. documentation format will be locally devised or directed by MAJCOM. This documentation will be maintained in accordance with AFM 37-139, table 37-15, rule 31.

A13.5. Other Audits. As part of the workload reconciliation purposes, similar audits will be performed on inpatient, outpatient, and expense workload reporting systems.